October 2024

Molina Healthcare

Medicaid

Preferred Drug List (Formulary)/ Lista de Medicamentos Preferidos (Formulario)

Discrimination is against the law

Molina Healthcare (Molina) follows the law. We treat all people equally.

We do not discriminate against anyone based on:

- Race
- Color
- National origin
- Age
- Disability
- Sex
- Religion

We provide free help and services to people with disabilities. We want you to be able to communicate with us easily.

We offer:

- Qualified sign language interpreters.
- Written information in many formats. These may include:
  - Large print
  - Audio
  - Accessible electronic formats
  - Other formats

We also provide free language services to people whose first language is not English. We offer:

- Qualified interpreters
- Information that is written in other languages

Contact us at (800) 424-4518 (TTY/TDD: 711) if you need any of these services.

The AlertLine offers confidential and anonymous reporting without fear of retaliation. If you believe there have been instances of non-compliance, potential fraud, waste or abuse or have experienced discrimination, you may file a report by calling the Molina AlertLine at (866) 606-3889 or online at https://molinahealthcare.alertline.com

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You may do this online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

Or you may do this by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019
TDD: (800) 537-7697

Complaint forms are available online. You may find them at http://www.hhs.gov/ocr/office/file/index.html.

Help in other languages

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 424-4518 (TTY/TDD: 711).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(800) 424-4518 (TTY/TDD: 711) 번으로 전화해 주십시오.

Vietnamese
CHÚ Ý: Nếu ban nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho ban. Gọi số (800) 424-4518 (TTY/TDD: 711).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (TTY/TDD: 711) (800) 424-4518.

Arabic
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان، اتصل برقم 1-800-424-4518) رقم هاتف الصم والبكم: 711) -قم هاتف الصم والبكم:) .

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa (800) 424-4518 (TTY/TDD: 711).

Farsi
توجه: اگر به زبان فارسی صحبت می کنید، خدمات راهنمای زبان به صورت رایگان برای شما در دسترس است. با شماره 4518-424 (800)TTY/TDD تعمارية ونه ته بينوايان 711)); تعمارية ونه ته بينوايان تماس بگیرید

Amharic
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል: ወደ ሚከተለው ቁጥር ይደውሉ

Urdu
دعیان دین: اگر آپ اردو بو لیتے ہیں تو مشت زبان کی مدد والی خل ما شت دستیاب ہیں۔ (711 بلس --424-800 (TTY/TDD) : 4518 میڈ لین. پرکریں کال۔

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 424-4518 (ATS: 711).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. ЗВОНИТЕ (800) 424-4518 (Телетайп: 711).

Hindi
ध्यान दें : यदि आप हिंदी बोलते है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है।
(800) 424-4518 (TTY/TDD: 711) पर कॉल करे ।

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer (800) 424-4518 (TTY/TDD: 711).

Bengali
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলেত পারেন, তাহেল নিঃখরচায় ভাষা সহায়তা পা রেষবা উপল আছে ফোন করন।
(800) 424-4518 (TTY/TDD: 711).

Bassa
Dè dɛ nià kɛ dyédé gbo: ɔ jǔ ké m̀ Bàsɔ ɔ-wùdù-po-nyɔ jǔ ní, nií, à wudu kà kò do po-poɔ bɛ́ ìn m̀ gbo kpáa. Đá (800) 424-4518 (TTY/TDD: 711).

CONTENTS/CONTENIDO

(10/01/2024)

FORMULARY GUIDE (ENGLISH)

INTRODUCTION

We are pleased to provide the *2024 Molina Healthcare (Molina) Preferred Drug List (Formulary)* as a useful reference and informational tool. This guide can help medical providers select clinically appropriate and cost-effective products for their patients.

The drugs in this guide have been reviewed by a Pharmacy and Therapeutics (P&T) Committee and are approved before being included. This guide reflects current medical practice as of the date of review.

The information in this guide is provided solely for the benefit of medical providers. We do not guarantee accuracy of such information. This guide is not intended to be comprehensive in nature. All the information in the guide is provided as a reference for drug therapy selection.

This guide is subject to state-specific regulations and rules, including, but not limited to, those about generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

Molina is not responsible for the actions or omissions of any medical provider based on information in this guide. The medical provider should check the drug manufacturer's product literature or standard references for more detailed information.

PREFACE

This guide is organized by sections. Each section is divided by therapeutic drug class by type.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

We use the services of a Pharmacy and Therapeutics Committee ("P&T Committee") to approve safe and clinically effective drug therapies. The P&T Committee is an advisory body of clinical professionals. The P&T Committee's voting members include physicians and pharmacists who all have a broad background of clinical and academic expertise on prescription drugs. Voting members of the P&T Committee must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers.

DRUG LIST PRODUCT DESCRIPTIONS

To help you understand which specific strengths and dosage forms are covered, some general guidelines are noted below.

- The first column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., LIPITOR). Generic drugs are listed in lowercase italics (e.g., atorvastatin).

- The second column (labeled Drug Tier) will list what tier the drug is placed on in the Drug Formulary.
- The third column (Requirements/Limits) contains any special requirements for coverage of your drug.
- If the OTC and prescription versions of the product are covered, then both are listed.
- Extended-release and delayed-release products require their own entry.
- Dosage forms will be consistent with the category and use where listed.

GENERIC SUBSTITUTION

Generic substitution is when your pharmacy may dispense a generic version instead of a prescribed brand-name product. In this guide, lowercase italicized type means a generic version is available. In most instances, if there's a generic product available, the brand-name version will become non-formulary. The generic product will be covered instead of the brand-name version. However, this guide is subject to state specific regulations and rules for generic substitution and mandatory generic rules apply where appropriate.

Prescription generic drugs are:

- Usually priced lower than their brand-name equivalents
- Approved by the U.S. Food and Drug Administration for safety and effectiveness. They are manufactured under the same strict standards that apply to brand-name drugs
- Tested in humans to make sure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter how safe and effective they are
- Manufactured in the same strength and dosage form as the brand-name drugs

When a generic drug is substituted for a brand-name drug, the generic should be just as safe and effective as the brand-name drug (therapeutic equivalence).

PLAN DESIGN

- This guide represents Molina and Virginia Medicaid's Common Core Formulary. Generic medications are typically available at the lowest cost. Brand-name medications usually cost more than generic versions. Medications not on the list will usually cost the most.

This guide lists drugs in the following manner:

Preferred Drugs
Non-Preferred Drugs

The medications listed in this guide are covered by Molina as represented. Molina covers certain medications on the list if utilization management criteria are met (i.e., Step Therapy, Prior Authorization, Quantity Limits, etc.). Molina will review requests for such medications outside of their listed criteria for medical necessity. If a medication is not listed, you may request a formulary exception for coverage. We will review medical necessity or formulary exception requests based on

drug-specific prior authorization criteria or standard non-formulary prescription request criteria. Log into **molinahealthcare.com** to check coverage.

PRIOR AUTHORIZATION REQUEST PROCEDURE

Prescriptions for medications requiring prior approval or for medications not included on the Molina Drug Formulary may be approved when medically necessary and when formulary options have proven not to work. When this happens, the physician may fax a completed drug prior authorization form to Molina at (844) 278-5731. You can find these forms at molinahealthcare.com. We will not consider trials of pharmaceutical samples as rationale for approving a prior authorization request.

PRIOR AUTHORIZATION HELPFUL HINTS

For the quickest response possible from Molina's pharmacy department, please provide relevant information with the Prior Authorization request.

The following are examples:

Class of Medication/Diagnosis	**Requested Clinical Information**
Cholesterol Lowering	Lipid Panel, Cardiovascular risk factors
Diabetes	A1c Report
Non-Formulary/Non-Preferred Medication	Medication Log and/or Progress Notes documenting previous use of Formulary medications

EXCLUDED SERVICES

Please note that certain medications are excluded. These include, but are not limited to:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- Drugs which have been recalled
- Experimental drugs or non-FDA-approved drugs
- Any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

NOTICE

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

LEGEND

AGE	Age Limit
CL	Closed Class Medication
MED	Max 90 mg Morphine Equivalent Dose per day
OTC	Over-the-counter, covered benefit with a prescription
PA	Prior Authorization
PA, QL	Quantity Limit is applied after Prior Authorization approval
QL	Quantity Limit
SP	Specialty Drug
ST	Step Therapy
lowercase	Indicates generic availability
UPPERCASE	Indicates brand availability

Product Name	Change	Notes	Effective Date
ADDERALL XR	Update to non-preferred	PA required	10/1/2024
ADEFOVIR DIPIVOXIL	Add to formulary as non-preferred	PA required	10/1/2024
AGAMREE	Add to formulary as non-preferred	PA required	10/1/2024
ALVESCO	Update to preferred Remove PA		10/1/2024
AMONDYS-45	Add to formulary as non-preferred	PA required	10/1/2024
ASMANEX HFA	Update to preferred Remove PA		10/1/2024
BARACLUDE	Add to formulary as non-preferred	PA required	10/1/2024
CARBAMAZEPINE ER TABLET	Update to preferred Remove PA		10/1/2024
DARUNAVIR TABLET	Update to preferred Remove PA		10/1/2024
DEFLAZACORT	Add to formulary as non-preferred Add age limit	PA required Age limit = Maximum age 2	10/1/2024
DEXTROAMPHETAMINE ER CAPSULE	Update to preferred Remove PA Add quantity limit	Quantity limit = 1 capsule per day	10/1/2024
DEXTROAMPHETAMINE-AMPHETAMINE ER CAPSULE	Update to preferred Remove PA		10/1/2024
EMFLAZA	Update to preferred Remove PA		10/1/2024
ENTECAVIR 0.5 MG TABLET	Remove PA Remove quantity limit		10/1/2024
ENTECAVIR 1 MG TABLET	Remove quantity limit		10/1/2024

EXONDYS-51	Add to formulary as non-preferred	PA required	10/1/2024
FLUTICASONE DISKUS	Update to non-preferred	PA required	10/1/2024
FLUTICASONE HFA	Update to non-preferred	PA required	10/1/2024
FULPHILA	Add to formulary as preferred		10/1/2024
FYLNETRA	Add to formulary as non-preferred	PA required	10/1/2024
GLUCAGON EMERGENCY KIT	Update to non-preferred	PA required	10/1/2024
GRANIX	Add to formulary as non-preferred	PA required	10/1/2024
GVOKE	Update to non-preferred	PA required	10/1/2024
GVOKE HYPOPEN	Update to non-preferred	PA required	10/1/2024
HEPSERA	Add to formulary as non-preferred	PA required	10/1/2024
INVOKAMET	Update to non-preferred	PA required	10/1/2024
INVOKANA	Update to non-preferred	PA required	10/1/2024
LAMIVUDINE HBV	Add to formulary as preferred		10/1/2024
LEUKINE	Add to formulary as non-preferred	PA required	10/1/2024
NEULASTA	Add to formulary as non-preferred	PA required	10/1/2024

NEULASTA ONPRO	Add to formulary as non-preferred	PA required	10/1/2024
NEUPOGEN	Add to formulary as preferred		10/1/2024
NIVESTYM	Add to formulary as non-preferred	PA required	10/1/2024
NUTROPIN AQ NUSPIN	Update to non-preferred	PA required	10/1/2024
NYVEPRIA	Add to formulary as non-preferred	PA required	10/1/2024
PREZISTA	Update to non-preferred	PA required	10/1/2024
QVAR REDIHALER	Update to preferred Remove PA		10/1/2024
RELEUKO	Add to formulary as non-preferred	PA required	10/1/2024
ROLVEDON	Add to formulary as non-preferred	PA required	10/1/2024
SIMLANDI(CF) AUTO-INJECTOR	Add to formulary as non-preferred Add age limit	PA required Age limit = Minimum age 2	10/1/2024
STIMUFEND	Add to formulary as non-preferred	PA required	10/1/2024
SYNJARDY XR	Update to preferred Remove PA		10/1/2024
TYENNE	Add to formulary as non-preferred Add age limit	PA required Age limit = Minimum age 2	10/1/2024
UDENYCA	Add to formulary as non-preferred	PA required	10/1/2024
VALTOCO	Update to non-preferred	PA required	10/1/2024

VEMLIDY	Add to formulary as non-preferred	PA required	10/1/2024
VILTEPSO	Add to formulary as non-preferred	PA required	10/1/2024
VYONDYS-53	Add to formulary as non-preferred	PA required	10/1/2024
VYVANSE CHEWABLE TABLET	Update to non-preferred	PA required	10/1/2024
ZARXIO	Update to non-preferred	PA required	10/1/2024
ZEGALOGUE	Update to preferred Remove PA		10/1/2024
ZIEXTENZO	Update to non-preferred	PA required	10/1/2024

GUÍA DE FORMULARIO (ESPAÑOL)

INTRODUCCIÓN

Nos complace proporcionar *Lista de Medicamentos Preferidos de [Molina Healthcare (Molina)] [2024] (Formulario)* como una herramienta de referencia e información útil. Esta guía puede ayudar a los proveedores médicos a seleccionar productos clínicamente apropiados y rentables para sus pacientes.

Los medicamentos que se indican en esta guía fueron revisados por un Comité de Farmacia y Terapéutica (P&T, *Pharmacy and Therapeutics*) y están aprobados antes de su inclusión. Esta guía refleja la práctica médica actual a la fecha de revisión.

La información en esta guía se proporciona únicamente para el beneficio de los proveedores médicos. No garantizamos la exactitud de dicha información. Esta guía no fue hecha con un propósito integral. Toda la información de esta guía se proporciona como referencia para la selección de la terapia con medicamentos.

Esta guía está sujeta a normas y reglamentos específicos del estado, incluidos, entre otros, aquellos relacionados con la sustitución genérica, los programas de sustancias de administración controlada, la preferencia de marcas y los genéricos obligatorios cuando corresponda.

[Molina] no asume la responsabilidad por las acciones u omisiones de cualquier proveedor médico en función de la información contenida en esta guía. El proveedor médico debe revisar la documentación del producto provista por el fabricante del medicamento o las referencias estándar para obtener información más detallada.

PREFACIO

Esta guía está organizada en secciones. Cada sección se divide según la clase terapéutica del fármaco, por tipo.

COMITÉ DE FARMACIA Y TERAPÉUTICA (P&T)

Utilizamos los servicios de un Comité de Farmacia y Terapéutica (P&T) para aprobar tratamientos con medicamentos seguros y clínicamente eficaces. El Comité de P&T es un organismo asesor de profesionales clínicos. Entre los miembros votantes del Comité de P&T, se encuentran médicos y farmacéuticos, los cuales tienen una amplia experiencia clínica y académica en medicamentos recetados. Los miembros votantes del Comité de P&T deben divulgar cualquier relación financiera o conflicto de intereses con cualquier fabricante farmacéutico.

DESCRIPCIONES DE LOS PRODUCTOS DE LA LISTA DE MEDICAMENTOS

Para ayudar a entender cuáles son las fortalezas específicas y las formas de dosificación cubiertas, algunas pautas generales se describen a continuación.

- En la primera columna del cuadro se indica el nombre del medicamento. Los medicamentos de marca están en letra mayúscula (p. ej., LIPITOR). Los medicamentos genéricos se indican en letra minúscula en cursiva (p. ej., atorvastatin).
- En la segunda columna (categoría de medicamento etiquetado) se indica en qué categoría se ubica el medicamento en el formulario.
- La tercera columna (Requisitos/límites) contiene cualquier requisito especial para la cobertura de su medicamento.
- Si las versiones de productos de venta libre (OTC, *Over The Counter*) y las versiones de productos con receta médica están cubiertas, se indican ambas.
- Los productos de liberación prolongada y de liberación retardada requieren su propia entrada.
- Las formas de dosificación serán coherentes con la categoría y el uso en que se clasificaron.

SUSTITUCIÓN GENÉRICA

La sustitución genérica es cuando su farmacia puede administrar una versión genérica en lugar de un producto de marca recetado. En esta guía, la letra minúscula en cursiva significa que hay una versión genérica disponible. En la mayoría de los casos, si hay un producto genérico disponible, la versión de marca registrada no tendrá formulario. El producto genérico estará cubierto en lugar de la versión de marca registrada. Sin embargo, esta guía está sujeta a regulaciones y normas específicas del estado sobre la sustitución genérica y se aplican normas genéricas obligatorias si corresponde.

Los medicamentos genéricos con receta médica cuentan con las siguientes características:

- Normalmente, tienen un precio menor que sus equivalentes de marca.
- Están aprobados por la Administración de Alimentos y Medicamentos de los EE. UU. en términos de seguridad y eficacia. Se fabrican bajo las mismas normas estrictas que se aplican a medicamentos de marca.
- Se probaron en humanos para garantizar que el genérico sea absorbido en el torrente sanguíneo en una tasa y extensión similares en comparación con el medicamento de marca (bioequivalencia). Los genéricos pueden ser diferentes de los de la marca en cuanto a tamaño, color e ingredientes inactivos, pero esto no altera lo efectivos ni seguros que son.
- Se fabrican con la misma concentración y dosificación que los medicamentos de marca.

Cuando un medicamento genérico es sustituido por un medicamento de marca, el medicamento genérico debe ser igual de efectivo y seguro que el medicamento de marca (equivalencia terapéutica).

DISEÑO DE PLANES

Esta guía representa el Formulario Básico Común de [Molina] y Virginia Medicaid. Los medicamentos que se presentan en el documento pueden tener un costo variable para el miembro del plan. Los medicamentos genéricos suelen estar disponibles al menor precio. Los medicamentos de marca, por lo general, serán más caros que las versiones genéricas. Los medicamentos que no están presentes en la lista suelen tener el mayor precio.

En esta guía se indican los medicamentos dela siguiente manera:

Categoría 1: Medicamentos Genéricos Preferidos
Categoría 2: Medicamentos de Marca Preferidos
Categoría 3: Medicamentos de Marca no Preferidos: Los medicamentos que no aparecen en el documento se consideran como “No Preferidos”

Los medicamentos que aparecen en esta guía están cubiertos por [Molina] según lo que se representa. [Molina] cubra algunos medicamentos de la lista si se cumplen los criterios de administración de utilización (es decir, terapia progresiva, autorización previa, límites de cantidad, etc.). [Molina] revisará las solicitudes de dichos medicamentos que estén fuera de los criterios enumerados se revisarán según la necesidad médica. Si un medicamento no aparece, puede solicitar una excepción de formulario para la cobertura. Revisaremos las solicitudes de necesidad médica o de excepción de formulario en función de los criterios de autorización previos específicos para el medicamento o los criterios estándar de solicitud de receta médica no convencional. Inicie sesión en **[molinahealthcare.com]** para revisar la cobertura.

PROCEDIMIENTO DE SOLICITUD DE AUTORIZACIÓN PREVIA

Las recetas de medicamentos que requieren aprobación previa o para medicamentos que no están incluidos en el Formulario de Medicamentos de [Molina] pueden ser aprobadas cuando son médicamente necesarias y cuando se haya demostrado que las alternativas del formulario no funcionan. Cuando esto ocurra, su proveedor puede enviar por fax un formulario completado de autorización previa de medicamentos a [Molina] al [(844) 278-5731]. Puede encontrar estos formularios en [molinahealthcare.com]. No consideraremos los ensayos de muestras farmacéuticas como justificativos para la aprobación de una solicitud de autorización previa.

CONSEJOS ÚTILES DE AUTORIZACIÓN PREVIA

Para la respuesta más rápida posible del Departamento de Farmacia de [Molina], proporcione la información pertinente con la solicitud de autorización previa.

Observe los siguientes ejemplos:

Clase de medicamento o diagnóstico	Información clínica solicitada
Reducción de colesterol	Perfil lipídico, factores de riego cardiovasculares
Diabetes	Resultados de prueba de A1c
Medicamento no preferido/fuera del formulario	Los Registros de Medicamentos o Notas de Progreso en los cuales se documente que el medicamento del formulario se utilizó con anterioridad

SERVICIOS EXCLUIDOS

Tenga en cuenta que algunos medicamentos están excluidos. Estos incluyen, entre otros:

- Medicamentos contra la anorexia, pérdida de peso o aumento de peso.
- Medicamentos para promover la fertilidad.
- Medicamentos para fines cosméticos o el crecimiento del cabello.
- Medicamentos para el tratamiento de disfunción sexual o eréctil; a menos que dichos medicamentos s utilicen para tratar una afección distinta de la disfunción eréctil; para la que los medicamentos estén aprobados por la FDA.
- Todos los medicamentos DESI (*Drug Efficacy Study Implementation*, Implementación del Estudio de la Eficacia de los Medicamentos) que, según la definición de la FDA, no tengan el novel requerido de eficacia. Recetas de compuestos, lo que incluye medicamentos DESI no cubiertos.
- Medicamentos que se hayan retirado del Mercado.
- Medicamentos experimentales o no aprobados por la FDA.
- Cualquier medicamento de venta bajo receta archivada que se comercialice por un fabricante no perteneciente al Programa de Devolución de Medicamentos de Medicaid.

AVISO

LEYENDA

AGE	Límite de edad
CL	Medicamentos de Clase Cerrada
MED	Dosis equivalente de morfina de 90 mg como máximo por día
OTC	Medicamento de venta libre, beneficio cubierto con una receta médica
PA	Autorización previa
PA, QL	Límite de cantidad que se aplica después de la aprobación de la Autorización Previa
QL	Límite de Cantidad
SP	Medicamento de especialidad
ST	Terapia progresiva
minúscula	Indica disponibilidad genérica
MAYÚSCULA	Indica disponibilidad de la marca

Product Name	Change	Notes	Effective Date
ADDERALL XR	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
ADEFOVIR DIPIVOXIL	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
AGAMREE	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
ALVESCO	Actualizar a preferido Eliminar autorización previa		10/1/2024
AMONDYS-45	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
ASMANEX HFA	Actualizar a preferido Eliminar autorización previa		10/1/2024
BARACLUDE	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
CARBAMAZEPINE ER TABLET	Actualizar a preferido Eliminar autorización previa		10/1/2024
DARUNAVIR TABLET	Actualizar a preferido Eliminar autorización previa		10/1/2024
DEFLAZACORT	Agregar al formulario como no preferido Agregar límite de edad	Se requiere autorización previa Límite de edad = edad máxima 2	10/1/2024
DEXTROAMPHETAMINE ER CAPSULE	Actualizar a preferido Eliminar autorización previa Agregar límite de cantidad	Límite de cantidad = 1 cápsula por día	10/1/2024
DEXTROAMPHETAMINE-AMPHETAMINE ER CAPSULE	Actualizar a preferido Eliminar autorización previa		10/1/2024
EMFLAZA	Actualizar a preferido Eliminar autorización previa		10/1/2024

ENTECAVIR 0.5 MG TABLET	Eliminar autorización previa Eliminar límite de cantidad		10/1/2024
ENTECAVIR 1 MG TABLET	Eliminar límite de cantidad		10/1/2024
EXONDYS-51	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
FLUTICASONE DISKUS	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
FLUTICASONE HFA	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
FULPHILA	Agregar al formulario como preferido		10/1/2024
FYLNETRA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
GLUCAGON EMERGENCY KIT	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
GRANIX	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
GVOKE	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
GVOKE HYPOPEN	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
HEPSERA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
INVOKAMET	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
INVOKANA	Actualizar a no preferido	Se requiere autorización previa	10/1/2024

LAMIVUDINE HBV	Agregar al formulario como preferido		10/1/2024
LEUKINE	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NEULASTA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NEULASTA ONPRO	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NEUPOGEN	Agregar al formulario como preferido		10/1/2024
NIVESTYM	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
NUTROPIN AQ NUSPIN	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
NYVEPRIA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
PREZISTA	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
QVAR REDIHALER	Actualizar a preferido Eliminar autorización previa		10/1/2024
RELEUKO	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
ROLVEDON	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
SIMLANDI(CF) AUTO-INJECTOR	Agregar al formulario como no preferido Agregar límite de edad	Se requiere autorización previa Age limit = Minimum age 2	10/1/2024
STIMUFEND	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024

SYNJARDY XR	Actualizar a preferido Eliminar autorización previa		10/1/2024
TYENNE	Agregar al formulario como no preferido Agregar límite de edad	Se requiere autorización previa Age limit = Minimum age 2	10/1/2024
UDENYCA	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VALTOCO	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
VEMLIDY	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VILTEPSO	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VYONDYS-53	Agregar al formulario como no preferido	Se requiere autorización previa	10/1/2024
VYVANSE CHEWABLE TABLET	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
ZARXIO	Actualizar a no preferido	Se requiere autorización previa	10/1/2024
ZEGALOGUE	Actualizar a preferido Eliminar autorización previa		10/1/2024
ZIEXTENZO	Actualizar a no preferido	Se requiere autorización previa	10/1/2024

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Drug Name	Formulary Status	Requirements/Limits
ACNE AGENTS: TOPICAL [OPEN CLASS]		
acne medication 10 external gel 10 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
acne medication 10 external lotion 10 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
acne medication 2.5 external gel 2.5 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
acne medication 5 external gel 5 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
acne medication 5 external lotion 5 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
adapalene external gel 0.1 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
benzoyl peroxide external gel 10 %, 2.5 %, 5 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
benzoyl peroxide external liquid 10 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
benzoyl peroxide wash external liquid 10 %, 5 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
clindamycin phos-benzoyl perox external gel 1.2-5 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
clindamycin phosphate external solution 1 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
clindamycin phosphate external swab 1 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
clindamycin phosphate gel 1 % external	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
erythromycin external solution 2 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
lintera wash external foam 10 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
tazarotene external foam 0.1 %	Preferred	PA (Eligible for auto-PA approval); AGE (Min 12 Years and Max 18 Years)

Drug Name	Formulary Status	Requirements/Limits
tretinoin external cream 0.025 %, 0.05 %, 0.1 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
tretinoin external gel 0.01 %, 0.025 %	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
clindamycin phosphate (Clindacin Etz External Swab 1 %)	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
clindamycin phosphate (Clindacin-P External Swab 1 %)	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
RETIN-A EXTERNAL CREAM 0.025 %, 0.05 %, 0.1 % (*tretinoin*)	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
RETIN-A EXTERNAL GEL 0.01 %, 0.025 % (*tretinoin*)	Preferred	PA (Eligible for auto-PA approval); AGE (Max 18 Years)
adapalene external cream 0.1 %	Non Preferred	PA; AGE (Max 18 Years)
adapalene external gel 0.3 %	Non Preferred	PA; AGE (Max 18 Years)
adapalene-benzoyl peroxide external gel 0.1-2.5 %, 0.3-2.5 %	Non Preferred	PA; AGE (Max 18 Years)
benzoyl peroxide-erythromycin external gel 5-3 %	Non Preferred	PA; AGE (Max 18 Years)
bp 10-1 external emulsion 10-1 %	Non Preferred	PA; AGE (Max 18 Years)
bp cleansing wash external emulsion 10-4 %	Non Preferred	PA; AGE (Max 18 Years)
bpo foaming cloths external 6 %	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phos-benzoyl perox external gel 1-5 %, 1.2-2.5 %, 1.2-3.75 %	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate external foam 1 %	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate external lotion 1 %	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate gel 1 % external	Non Preferred	PA; AGE (Max 18 Years)
clindamycin-tretinoin external gel 1.2-0.025 %	Non Preferred	PA; AGE (Max 18 Years)
dapsone external gel 5 %, 7.5 %	Non Preferred	PA; AGE (Max 18 Years)
ery external pad 2 %	Non Preferred	PA; AGE (Max 18 Years)

Drug Name	Formulary Status	Requirements/Limits
erythromycin external gel 2 %	Non Preferred	PA; AGE (Max 18 Years)
sodium sulfacetamide external shampoo 10 %	Non Preferred	PA; AGE (Max 18 Years)
sodium sulfacetamide wash external liquid 10 %	Non Preferred	PA; AGE (Max 18 Years)
sss 10-5 external cream 10-5 %	Non Preferred	PA; AGE (Max 18 Years)
sss 10-5 external foam 10-5 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium (acne) external lotion 10 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium (cleans) external gel 10 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium external liquid 10 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur external cream 10-2 %, 10-5 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur external liquid 10-2 %, 10-5 %, 9-4 %, 9-4.5 %, 9.8-4.8 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur external lotion 10-5 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur external pad 10-4 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur external suspension 10-5 %, 8-4 %	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sod-sulfur wash external liquid 9-4.5 %	Non Preferred	PA; AGE (Max 18 Years)
tazarotene external cream 0.05 %, 0.1 %	Non Preferred	PA; AGE (Max 18 Years)
tazarotene external gel 0.05 %, 0.1 %	Non Preferred	PA; AGE (Max 18 Years)
tretinoin external gel 0.05 %	Non Preferred	PA; AGE (Max 18 Years)
tretinoin microsphere external gel 0.04 %, 0.08 %, 0.1 %	Non Preferred	PA; AGE (Max 18 Years)
tretinoin microsphere pump external gel 0.04 %, 0.08 %, 0.1 %	Non Preferred	PA; AGE (Max 18 Years)
ACANYA EXTERNAL GEL 1.2-2.5 % (*clindamycin phos-benzoyl perox*)	Non Preferred	PA; AGE (Max 18 Years)
ALTRENO EXTERNAL LOTION 0.05 % (*tretinoin*)	Non Preferred	PA; AGE (Max 18 Years)
ARAZLO EXTERNAL LOTION 0.045 % (*tazarotene*)	Non Preferred	PA; AGE (Max 18 Years)
ATRALIN EXTERNAL GEL 0.05 % (*tretinoin*)	Non Preferred	PA; AGE (Max 18 Years)

Drug Name	Formulary Status	Requirements/Limits
sulfacetamide sodium-sulfur (Avar Cleanser External Liquid 10-5 %)	Non Preferred	PA; AGE (Max 18 Years)
AVAR LS CLEANSER EXTERNAL LIQUID 10-2 % (*sulfacetamide sodium-sulfur*)	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur (Avar-E Emollient External Cream 10-5 %)	Non Preferred	PA; AGE (Max 18 Years)
sulfacetamide sodium-sulfur (Avar-E Green External Cream 10-5 %)	Non Preferred	PA; AGE (Max 18 Years)
AVAR-E LS EXTERNAL CREAM 10-2 % (*sulfacetamide sodium-sulfur*)	Non Preferred	PA; AGE (Max 18 Years)
BENZAMYCIN EXTERNAL GEL 5-3 % (*benzoyl peroxide-erythromycin*)	Non Preferred	PA; AGE (Max 18 Years)
BENZEFOAM EXTERNAL FOAM 5.3 % (*benzoyl peroxide*)	Non Preferred	PA; AGE (Max 18 Years)
CABTREO EXTERNAL GEL 0.15-3.1-1.2 % (*adapalene-benzoyl per-clindamy*)	Non Preferred	PA; AGE (Min 12 Years)
CLEOCIN-T EXTERNAL LOTION 1 % (*clindamycin phosphate*)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN ETZ EXTERNAL KIT 1 % (*clindamycin phos & cleanser*)	Non Preferred	PA; AGE (Max 18 Years)
clindamycin phosphate (Clindacin External Foam 1 %)	Non Preferred	PA; AGE (Max 18 Years)
CLINDACIN PAC EXTERNAL KIT 1 % (*clindamycin phos & cleanser*)	Non Preferred	PA; AGE (Max 18 Years)
CLINDAGEL EXTERNAL GEL 1 % (*clindamycin phosphate*)	Non Preferred	PA; AGE (Max 18 Years)
DERMACINRX ATRIX ANTIBAC WASH EXTERNAL LIQUID 2 % (*salicylic acid*)	Non Preferred	PA; AGE (Max 18 Years)
ERYGEL EXTERNAL GEL 2 % (*erythromycin*)	Non Preferred	PA; AGE (Max 18 Years)
EVOCLIN EXTERNAL FOAM 1 % (*clindamycin phosphate*)	Non Preferred	PA; AGE (Max 18 Years)
FABIOR EXTERNAL FOAM 0.1 % (*tazarotene*)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
clindamycin-benzoyl per (refr) (Neuac External Gel 1.2-5 %)	Non Preferred	PA; AGE (Max 18 Years)
NEUAC EXTERNAL KIT 1.2-5 % (*clindamycin-benzoyl per-moist*)	Non Preferred	PA; AGE (Max 18 Years)
ONEXTON EXTERNAL GEL 1.2-3.75 % (*clindamycin phos-benzoyl perox*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS EXTERNAL CREAM 10 % (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS EXTERNAL LOTION 9.8 % (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS EXTERNAL SHAMPOO 10 % (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)

Drug Name	Formulary Status	Requirements/Limits
OVACE PLUS WASH EXTERNAL GEL 10 % (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE PLUS WASH EXTERNAL LIQUID 10 % (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
OVACE WASH EXTERNAL LIQUID 10 % (*sulfacetamide sodium*)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO EXTERNAL GEL 0.04 %, 0.1 % (*tretinoin microsphere*)	Non Preferred	PA; AGE (Max 18 Years)
RETIN-A MICRO PUMP EXTERNAL GEL 0.04 %, 0.06 %, 0.08 %, 0.1 % (*tretinoin microsphere*)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN EXTERNAL KIT 9-4.5 % (*sulfacetamide-sulfur-cleanser*)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN WASH EXTERNAL LIQUID 9-4.5 % (*sulfacetamide sodium-sulfur*)	Non Preferred	PA; AGE (Max 18 Years)
SUMADAN XLT EXTERNAL KIT 9-4.5 % (*sulfacetamide-sulfur-sunscreen*)	Non Preferred	PA; AGE (Max 18 Years)
SUMAXIN CP EXTERNAL KIT 10-4 % (*sulfacetamide-sulfur-cleanser*)	Non Preferred	PA; AGE (Max 18 Years)
WINLEVI EXTERNAL CREAM 1 % (*clascoterone*)	Non Preferred	PA; AGE (Min 12 Years and Max 18 Years)
ZIANA EXTERNAL GEL 1.2-0.025 % (*clindamycin-tretinoin*)	Non Preferred	PA; AGE (Max 18 Years)
ZMA CLEAR EXTERNAL SUSPENSION 9-4.5 % (*sulfacetamide sodium-sulfur*)	Non Preferred	PA; AGE (Max 18 Years)
ALZHEIMER'S AGENTS [OPEN CLASS]		
donepezil hcl oral tablet 10 mg, 23 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
donepezil hcl oral tablet dispersible 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
memantine hcl oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
rivastigmine transdermal patch 24 hour 13.3 mg/24hr, 4.6 mg/24hr, 9.5 mg/24hr	Preferred	90-day fill allowed after two 1-month fills
galantamine hydrobromide er oral capsule extended release 24 hour 16 mg, 24 mg, 8 mg	Non Preferred	PA
galantamine hydrobromide oral solution 4 mg/ml	Non Preferred	PA
galantamine hydrobromide oral tablet 12 mg, 4 mg, 8 mg	Non Preferred	PA
memantine hcl er oral capsule extended release 24 hour 14 mg, 21 mg, 28 mg, 7 mg	Non Preferred	PA
memantine hcl oral solution 2 mg/ml	Non Preferred	PA; 90-day fill allowed after two 1-month fills
rivastigmine tartrate oral capsule 1.5 mg, 3 mg, 4.5 mg, 6 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
ADLARITY TRANSDERMAL PATCH WEEKLY 10 MG/DAY, 5 MG/DAY (*donepezil hcl*)	Non Preferred	PA
ARICEPT ORAL TABLET 10 MG, 23 MG, 5 MG (*donepezil hcl*)	Non Preferred	PA
EXELON TRANSDERMAL PATCH 24 HOUR 13.3 MG/24HR, 4.6 MG/24HR, 9.5 MG/24HR (*rivastigmine*)	Non Preferred	PA
NAMZARIC ORAL CAPSULE ER 24 HOUR THERAPY PACK 7 & 14 & 21 &28 -10 MG (*memantine hcl-donepezil hcl*)	Non Preferred	PA; QL (28 EA per 180 days)
NAMZARIC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 14-10 MG, 21-10 MG, 28-10 MG, 7-10 MG (*memantine hcl-donepezil hcl*)	Non Preferred	PA
ANDROGENIC AGENTS [OPEN CLASS]		
testosterone transdermal gel 1.62 %, 20.25 mg/act (1.62%)	Preferred	AGE (Min 18 Years)
ANDRODERM TRANSDERMAL PATCH 24 HOUR 2 MG/24HR, 4 MG/24HR (*testosterone*)	Preferred	AGE (Min 18 Years)
ANDROGEL PUMP TRANSDERMAL GEL 20.25 MG/ACT (1.62%) (*testosterone*)	Preferred	AGE (Min 18 Years)
testosterone transdermal gel 10 mg/act (2%), 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)	Non Preferred	PA; AGE (Min 18 Years)
testosterone transdermal solution 30 mg/act	Non Preferred	PA; AGE (Min 18 Years)
FORTESTA TRANSDERMAL GEL 10 MG/ACT (2%) (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
NATESTO NASAL GEL 5.5 MG/ACT (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
TESTIM TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO PUMP TRANSDERMAL GEL 12.5 MG/ACT (1%) (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
VOGELXO TRANSDERMAL GEL 50 MG/5GM (1%) (*testosterone*)	Non Preferred	PA; AGE (Min 18 Years)
ANTI-ALLERGENS: ORAL [OPEN CLASS]		
GRASTEK SUBLINGUAL TABLET SUBLINGUAL 2800 BAU (*timothy grass pollen allergen*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 5 Years)
ODACTRA SUBLINGUAL TABLET SUBLINGUAL 12 SQ-HDM (*dust mite mixed allergen ext*)	Non Preferred	PA; AGE (Min 12 Years and Max 65 Years)
ORALAIR SUBLINGUAL TABLET SUBLINGUAL 300 IR (*grass mix pollens allergen ext*)	Non Preferred	PA; AGE (Min 5 Years)
PALFORZIA (12 MG DAILY DOSE) ORAL 2 X 1 MG & 10 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (120 MG DAILY DOSE) ORAL 20 MG & 100 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (160 MG DAILY DOSE) ORAL 3 X 20 MG & 100 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)

Drug Name	Formulary Status	Requirements/Limits
PALFORZIA (20 MG DAILY DOSE) ORAL 20 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (200 MG DAILY DOSE) ORAL 2 X 100 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (240 MG DAILY DOSE) ORAL 2 X 20 MG & 2 X 100 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (3 MG DAILY DOSE) ORAL 3 X 1 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (300 MG MAINTENANCE) ORAL PACKET 300 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (300 MG TITRATION) ORAL PACKET 300 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (40 MG DAILY DOSE) ORAL 2 X 20 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (6 MG DAILY DOSE) ORAL 6 X 1 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA (80 MG DAILY DOSE) ORAL 4 X 20 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
PALFORZIA INITIAL ESCALATION ORAL 0.5 & 1 & 1.5 & 3 & 6 MG (*peanut powder-dnfp*)	Non Preferred	SP; PA; AGE (Min 4 Years)
RAGWITEK SUBLINGUAL TABLET SUBLINGUAL 12 AMB A 1-U (*short ragweed pollen ext*)	Non Preferred	PA; AGE (Min 5 Years)
ANTIBIOTICS: INHALED [CLOSED CLASS]		
tobramycin nebulization solution 300 mg/5ml inhalation	Preferred	SP; QL (280 ML per 28 days); AGE (Min 6 Years)
BETHKIS INHALATION NEBULIZATION SOLUTION 300 MG/4ML (*tobramycin*)	Preferred	SP; QL (224 ML per 28 days); AGE (Min 6 Years)
KITABIS PAK INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	Preferred	SP; QL (280 ML per 28 days); AGE (Min 6 Years)
TOBI PODHALER INHALATION CAPSULE 28 MG (*tobramycin*)	Preferred	SP; PA; QL (224 EA per 28 days); AGE (Min 6 Years)
tobramycin inhalation nebulization solution 300 mg/4ml	Non Preferred	SP; PA; QL (224 ML per 28 days); AGE (Min 6 Years)
tobramycin nebulization solution 300 mg/5ml inhalation	Non Preferred	SP; PA; QL (280 ML per 28 days); AGE (Min 6 Years)
ARIKAYCE INHALATION SUSPENSION 590 MG/8.4ML (*amikacin sulfate liposome*)	Non Preferred	PA; QL (235.2 ML per 28 days); AGE (Min 18 Years)
CAYSTON INHALATION SOLUTION RECONSTITUTED 75 MG (*aztreonam lysine*)	Non Preferred	SP; PA; QL (84 ML per 28 days); AGE (Min 7 Years)
TOBI INHALATION NEBULIZATION SOLUTION 300 MG/5ML (*tobramycin*)	Non Preferred	SP; PA; QL (280 ML per 28 days); AGE (Min 6 Years)
ANTICOAGULANTS [CLOSED CLASS]		
enoxaparin sodium injection solution 300 mg/3ml	Preferred	
enoxaparin sodium injection solution prefilled syringe 100 mg/ml, 120 mg/0.8ml, 150 mg/ml, 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml	Preferred	

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
PA - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **RX** - Prescription Drug **SP** - Specialty Drug

Drug Name	Formulary Status	Requirements/Limits
warfarin sodium oral tablet 1 mg, 10 mg, 2 mg, 2.5 mg, 3 mg, 4 mg, 5 mg, 6 mg, 7.5 mg	Preferred	90-day fill allowed after two 1-month fills
ELIQUIS DVT/PE STARTER PACK ORAL TABLET THERAPY PACK 5 MG (*apixaban*)	Preferred	
ELIQUIS ORAL TABLET 2.5 MG, 5 MG (*apixaban*)	Preferred	90-day fill allowed after two 1-month fills
warfarin sodium (Jantoven Oral Tablet 1 Mg, 10 Mg, 2 Mg, 2.5 Mg, 3 Mg, 4 Mg, 5 Mg, 6 Mg, 7.5 Mg)	Preferred	90-day fill allowed after two 1-month fills
PRADAXA ORAL CAPSULE 110 MG, 150 MG, 75 MG (*dabigatran etexilate mesylate*)	Preferred	90-day fill allowed after two 1-month fills
XARELTO ORAL SUSPENSION RECONSTITUTED 1 MG/ML (*rivaroxaban*)	Preferred	90-day fill allowed after two 1-month fills
XARELTO ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG (*rivaroxaban*)	Preferred	90-day fill allowed after two 1-month fills
XARELTO STARTER PACK ORAL TABLET THERAPY PACK 15 & 20 MG (*rivaroxaban*)	Preferred	
dabigatran etexilate mesylate oral capsule 110 mg, 150 mg, 75 mg	Non Preferred	PA
fondaparinux sodium subcutaneous solution 10 mg/0.8ml, 2.5 mg/0.5ml, 5 mg/0.4ml, 7.5 mg/0.6ml	Non Preferred	PA
ARIXTRA SUBCUTANEOUS SOLUTION 10 MG/0.8ML, 2.5 MG/0.5ML, 5 MG/0.4ML, 7.5 MG/0.6ML (*fondaparinux sodium*)	Non Preferred	PA
FRAGMIN SUBCUTANEOUS SOLUTION 10000 UNIT/4ML, 95000 UNIT/3.8ML (*dalteparin sodium*)	Non Preferred	PA
FRAGMIN SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10000 UNIT/ML, 12500 UNIT/0.5ML, 15000 UNIT/0.6ML, 18000 UNT/0.72ML, 2500 UNIT/0.2ML, 5000 UNIT/0.2ML, 7500 UNIT/0.3ML (*dalteparin sodium*)	Non Preferred	PA
LOVENOX INJECTION SOLUTION 300 MG/3ML (*enoxaparin sodium*)	Non Preferred	PA
LOVENOX INJECTION SOLUTION PREFILLED SYRINGE 100 MG/ML, 120 MG/0.8ML, 150 MG/ML, 30 MG/0.3ML, 40 MG/0.4ML, 60 MG/0.6ML, 80 MG/0.8ML (*enoxaparin sodium*)	Non Preferred	PA
PRADAXA ORAL PACKET 110 MG, 150 MG, 20 MG, 30 MG, 40 MG, 50 MG (*dabigatran etexilate mesylate*)	Non Preferred	PA; AGE (Max 12 Years)
SAVAYSA ORAL TABLET 15 MG, 30 MG, 60 MG (*edoxaban tosylate*)	Non Preferred	PA
ANTICONVULSANTS [CLOSED CLASS]		
carbamazepine er tablet extended release 12 hour 100 mg oral	Preferred	
carbamazepine er tablet extended release 12 hour 200 mg oral	Preferred	
carbamazepine er tablet extended release 12 hour 400 mg oral	Preferred	
carbamazepine oral suspension 100 mg/5ml, 200 mg/10ml	Preferred	90-day fill allowed after two 1-month fills
carbamazepine oral tablet 200 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
carbamazepine oral tablet chewable 100 mg	Preferred	90-day fill allowed after two 1-month fills
clobazam oral suspension 2.5 mg/ml	Preferred	
clobazam oral tablet 10 mg, 20 mg	Preferred	
clonazepam oral tablet 0.5 mg, 1 mg, 2 mg	Preferred	
diazepam rectal gel 10 mg, 2.5 mg, 20 mg	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
divalproex sodium er oral tablet extended release 24 hour 250 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
divalproex sodium oral capsule delayed release sprinkle 125 mg	Preferred	90-day fill allowed after two 1-month fills
divalproex sodium oral tablet delayed release 125 mg, 250 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
ethosuximide oral capsule 250 mg	Preferred	AGE (Min 3 Years); 90-day fill allowed after two 1-month fills
ethosuximide oral solution 250 mg/5ml	Preferred	AGE (Min 3 Years); 90-day fill allowed after two 1-month fills
lacosamide oral tablet 100 mg, 150 mg, 200 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
lacosamide solution 10 mg/ml oral	Preferred	90-day fill allowed after two 1-month fills
lamotrigine er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 250 mg, 300 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
lamotrigine oral tablet 100 mg, 150 mg, 200 mg, 25 mg	Preferred	90-day fill allowed after two 1-month fills
lamotrigine oral tablet chewable 25 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
lamotrigine oral tablet dispersible 100 mg, 200 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
levetiracetam er oral tablet extended release 24 hour 500 mg, 750 mg	Preferred	90-day fill allowed after two 1-month fills
levetiracetam oral solution 100 mg/ml	Preferred	90-day fill allowed after two 1-month fills
levetiracetam oral tablet 1000 mg, 250 mg, 500 mg, 750 mg	Preferred	90-day fill allowed after two 1-month fills
oxcarbazepine oral tablet 150 mg, 300 mg, 600 mg	Preferred	90-day fill allowed after two 1-month fills
phenobarbital oral elixir 20 mg/5ml	Preferred	
phenobarbital oral tablet 100 mg, 15 mg, 16.2 mg, 30 mg, 32.4 mg, 60 mg, 64.8 mg, 97.2 mg	Preferred	
phenytoin oral suspension 100 mg/4ml, 125 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
phenytoin oral tablet chewable 50 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
phenytoin sodium extended oral capsule 100 mg, 200 mg, 300 mg	Preferred	90-day fill allowed after two 1-month fills
primidone oral tablet 125 mg	Preferred	
primidone oral tablet 250 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
tiagabine hcl oral tablet 12 mg, 16 mg, 2 mg, 4 mg	Preferred	90-day fill allowed after two 1-month fills
topiramate oral capsule sprinkle 15 mg, 25 mg	Preferred	90-day fill allowed after two 1-month fills
topiramate oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
valproic acid oral capsule 250 mg	Preferred	90-day fill allowed after two 1-month fills
valproic acid oral solution 250 mg/5ml, 500 mg/10ml	Preferred	90-day fill allowed after two 1-month fills
zonisamide oral capsule 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
CARBATROL ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine*)	Preferred	90-day fill allowed after two 1-month fills
DIASTAT ACUDIAL RECTAL GEL 10 MG (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DIASTAT PEDIATRIC RECTAL GEL 2.5 MG (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 2 Years)
DILANTIN ORAL CAPSULE 30 MG (*phenytoin sodium extended*)	Preferred	
EPIDIOLEX ORAL SOLUTION 100 MG/ML (*cannabidiol*)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 1 Years)
carbamazepine (Epitol Oral Tablet 200 Mg)	Preferred	90-day fill allowed after two 1-month fills
LAMICTAL ODT ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 42 X 50 MG & 14X100 MG (*lamotrigine*)	Preferred	
NAYZILAM NASAL SOLUTION 5 MG/0.1ML (*midazolam (anticonvulsant)*)	Preferred	PA (Eligible for auto-PA approval); QL (10 EA per 30 days); AGE (Min 12 Years)
phenytoin (Phenytoin Infatabs Oral Tablet Chewable 50 Mg)	Preferred	90-day fill allowed after two 1-month fills
levetiracetam (Roweepra Oral Tablet 500 Mg)	Preferred	90-day fill allowed after two 1-month fills
lamotrigine (Subvenite Oral Tablet 100 Mg, 150 Mg, 200 Mg, 25 Mg)	Preferred	90-day fill allowed after two 1-month fills
TEGRETOL-XR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 400 MG (*carbamazepine*)	Preferred	90-day fill allowed after two 1-month fills
TRILEPTAL ORAL SUSPENSION 300 MG/5ML (*oxcarbazepine*)	Preferred	90-day fill allowed after two 1-month fills
VALTOCO 10 MG DOSE NASAL LIQUID 10 MG/0.1ML (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)

Drug Name	Formulary Status	Requirements/Limits
VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 7.5 MG/0.1ML (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)
VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 10 MG/0.1ML (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)
VALTOCO 5 MG DOSE NASAL LIQUID 5 MG/0.1ML (*diazepam*)	Preferred	QL (10 EA per 30 days); AGE (Min 6 Years)
carbamazepine er oral capsule extended release 12 hour 100 mg, 200 mg, 300 mg	Non Preferred	PA
carbamazepine er tablet extended release 12 hour 100 mg oral	Non Preferred	Authorized generic only; PA
carbamazepine er tablet extended release 12 hour 200 mg oral	Non Preferred	Authorized generic only; PA
carbamazepine er tablet extended release 12 hour 400 mg oral	Non Preferred	Authorized generic only; PA
clonazepam oral tablet dispersible 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg	Non Preferred	PA
clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg	Non Preferred	PA
felbamate oral suspension 600 mg/5ml	Non Preferred	PA
felbamate oral tablet 400 mg, 600 mg	Non Preferred	PA
lacosamide oral solution 100 mg/10ml, 50 mg/5ml	Non Preferred	PA
lacosamide solution 10 mg/ml oral	Non Preferred	PA
lamotrigine oral kit 21 x 25 mg & 7 x 50 mg, 25 & 50 & 100 mg, 42 x 50 mg & 14x100 mg	Non Preferred	PA
lamotrigine starter kit-blue oral kit 35 x 25 mg	Non Preferred	PA
lamotrigine starter kit-green oral kit 84 x 25 mg & 14x100 mg	Non Preferred	PA
lamotrigine starter kit-orange oral kit 42 x 25 mg & 7 x 100 mg	Non Preferred	PA
methsuximide oral capsule 300 mg	Non Preferred	PA
oxcarbazepine er oral tablet extended release 24 hour 150 mg, 300 mg, 600 mg	Non Preferred	PA
oxcarbazepine oral suspension 300 mg/5ml	Non Preferred	PA
rufinamide oral suspension 40 mg/ml	Non Preferred	PA
rufinamide oral tablet 200 mg, 400 mg	Non Preferred	PA
topiramate er oral capsule er 24 hour sprinkle 100 mg, 150 mg, 200 mg, 25 mg, 50 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
topiramate er oral capsule extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	Non Preferred	PA
vigabatrin oral packet 500 mg	Non Preferred	PA
vigabatrin oral tablet 500 mg	Non Preferred	PA
APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG (*eslicarbazepine acetate*)	Non Preferred	PA
BANZEL ORAL SUSPENSION 40 MG/ML (*rufinamide*)	Non Preferred	PA
BANZEL ORAL TABLET 200 MG, 400 MG (*rufinamide*)	Non Preferred	PA
BRIVIACT ORAL SOLUTION 10 MG/ML (*brivaracetam*)	Non Preferred	PA
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 50 MG, 75 MG (*brivaracetam*)	Non Preferred	PA
CELONTIN ORAL CAPSULE 300 MG (*methsuximide*)	Non Preferred	PA
DEPAKOTE ER ORAL TABLET EXTENDED RELEASE 24 HOUR 250 MG, 500 MG (*divalproex sodium*)	Non Preferred	PA
DEPAKOTE ORAL TABLET DELAYED RELEASE 125 MG, 250 MG, 500 MG (*divalproex sodium*)	Non Preferred	PA
DEPAKOTE SPRINKLES ORAL CAPSULE DELAYED RELEASE SPRINKLE 125 MG (*divalproex sodium*)	Non Preferred	PA
DIACOMIT ORAL CAPSULE 250 MG, 500 MG (*stiripentol*)	Non Preferred	SP; PA
DIACOMIT ORAL PACKET 250 MG, 500 MG (*stiripentol*)	Non Preferred	SP; PA
DILANTIN INFATABS ORAL TABLET CHEWABLE 50 MG (*phenytoin*)	Non Preferred	PA
DILANTIN ORAL CAPSULE 100 MG (*phenytoin sodium extended*)	Non Preferred	PA
DILANTIN ORAL SUSPENSION 125 MG/5ML (*phenytoin*)	Non Preferred	PA
DILANTIN-125 ORAL SUSPENSION 125 MG/5ML (*phenytoin*)	Non Preferred	PA
ELEPSIA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 1500 MG (*levetiracetam*)	Non Preferred	PA
EPRONTIA ORAL SOLUTION 25 MG/ML (*topiramate*)	Non Preferred	PA
EQUETRO ORAL CAPSULE EXTENDED RELEASE 12 HOUR 100 MG, 200 MG, 300 MG (*carbamazepine (antipsychotic)*)	Non Preferred	PA
FELBATOL ORAL SUSPENSION 600 MG/5ML (*felbamate*)	Non Preferred	PA
FELBATOL ORAL TABLET 400 MG, 600 MG (*felbamate*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
FINTEPLA ORAL SOLUTION 2.2 MG/ML (*fenfluramine hcl*)	Non Preferred	PA; AGE (Min 2 Years)
FYCOMPA ORAL SUSPENSION 0.5 MG/ML (*perampanel*)	Non Preferred	PA
FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*perampanel*)	Non Preferred	PA
KEPPRA ORAL SOLUTION 100 MG/ML (*levetiracetam*)	Non Preferred	PA
KEPPRA ORAL TABLET 1000 MG, 250 MG, 500 MG, 750 MG (*levetiracetam*)	Non Preferred	PA
KEPPRA XR ORAL TABLET EXTENDED RELEASE 24 HOUR 500 MG, 750 MG (*levetiracetam*)	Non Preferred	PA
KLONOPIN ORAL TABLET 0.5 MG, 1 MG, 2 MG (*clonazepam*)	Non Preferred	PA
LAMICTAL ODT ORAL TABLET DISPERSIBLE 100 MG, 200 MG, 25 MG, 50 MG (*lamotrigine*)	Non Preferred	PA
LAMICTAL ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG (*lamotrigine*)	Non Preferred	PA
LAMICTAL ORAL TABLET CHEWABLE 25 MG, 5 MG (*lamotrigine*)	Non Preferred	PA
LAMICTAL STARTER ORAL KIT 35 X 25 MG, 42 X 25 MG & 7 X 100 MG, 84 X 25 MG & 14X100 MG (*lamotrigine*)	Non Preferred	PA
LAMICTAL XR ORAL KIT 21 X 25 MG & 7 X 50 MG, 25 & 50 & 100 MG, 50 & 100 & 200 MG (*lamotrigine*)	Non Preferred	PA
LAMICTAL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 250 MG, 300 MG, 50 MG (*lamotrigine*)	Non Preferred	PA
LIBERVANT BUCCAL FILM 10 MG, 12.5 MG, 15 MG, 5 MG, 7.5 MG (*diazepam*)	Non Preferred	PA; QL (10 EA per 30 days); AGE (Min 2 Years and Max 5 Years)
MYSOLINE ORAL TABLET 250 MG, 50 MG (*primidone*)	Non Preferred	PA
ONFI ORAL SUSPENSION 2.5 MG/ML (*clobazam*)	Non Preferred	PA
ONFI ORAL TABLET 10 MG, 20 MG (*clobazam*)	Non Preferred	PA
OXTELLAR XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG, 600 MG (*oxcarbazepine*)	Non Preferred	PA
phenytoin sodium extended (Phenytek Oral Capsule 200 Mg, 300 Mg)	Non Preferred	PA
QUDEXY XR ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*topiramate*)	Non Preferred	PA
SABRIL ORAL PACKET 500 MG (*vigabatrin*)	Non Preferred	PA
SABRIL ORAL TABLET 500 MG (*vigabatrin*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG (*levetiracetam*)	Non Preferred	PA
lamotrigine (Subvenite Starter Kit-Blue Oral Kit 35 X 25 Mg)	Non Preferred	PA
lamotrigine (Subvenite Starter Kit-Green Oral Kit 84 X 25 Mg & 14X100 Mg)	Non Preferred	PA
lamotrigine (Subvenite Starter Kit-Orange Oral Kit 42 X 25 Mg & 7 X 100 Mg)	Non Preferred	PA
SYMPAZAN ORAL FILM 10 MG, 20 MG, 5 MG (*clobazam*)	Non Preferred	PA
TEGRETOL ORAL SUSPENSION 100 MG/5ML (*carbamazepine*)	Non Preferred	PA
TEGRETOL ORAL TABLET 200 MG (*carbamazepine*)	Non Preferred	PA
TOPAMAX ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG (*topiramate*)	Non Preferred	PA
TOPAMAX SPRINKLE ORAL CAPSULE SPRINKLE 15 MG, 25 MG (*topiramate*)	Non Preferred	PA
TRILEPTAL ORAL TABLET 150 MG, 300 MG, 600 MG (*oxcarbazepine*)	Non Preferred	PA
TROKENDI XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (*topiramate*)	Non Preferred	PA
vigabatrin (Vigadrone Oral Packet 500 Mg)	Non Preferred	PA
vigabatrin (Vigadrone Oral Tablet 500 Mg)	Non Preferred	PA
vigabatrin (Vigpoder Oral Packet 500 Mg)	Non Preferred	PA
VIMPAT ORAL SOLUTION 10 MG/ML (*lacosamide*)	Non Preferred	PA
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG (*lacosamide*)	Non Preferred	PA
XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG (*cenobamate*)	Non Preferred	PA
XCOPRI (350 MG DAILY DOSE) ORAL TABLET THERAPY PACK 150 & 200 MG (*cenobamate*)	Non Preferred	PA
XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG (*cenobamate*)	Non Preferred	PA
XCOPRI ORAL TABLET THERAPY PACK 14 X 12.5 MG & 14 X 25 MG, 14 X 150 MG & 14 X200 MG, 14 X 50 MG & 14 X100 MG (*cenobamate*)	Non Preferred	PA
ZARONTIN ORAL CAPSULE 250 MG (*ethosuximide*)	Non Preferred	PA; AGE (Min 3 Years)
ZARONTIN ORAL SOLUTION 250 MG/5ML (*ethosuximide*)	Non Preferred	PA; AGE (Min 3 Years)

Drug Name	Formulary Status	Requirements/Limits
ZONISADE ORAL SUSPENSION 100 MG/5ML (*zonisamide*)	Non Preferred	PA
ZTALMY ORAL SUSPENSION 50 MG/ML (*ganaxolone*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ANTIDEPRESSANTS: OTHER [OPEN CLASS]		
bupropion hcl er (sr) oral tablet extended release 12 hour 100 mg, 150 mg, 200 mg	Preferred	90-day fill allowed after two 1-month fills
bupropion hcl er (xl) oral tablet extended release 24 hour 150 mg, 300 mg	Preferred	90-day fill allowed after two 1-month fills
bupropion hcl oral tablet 100 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
desvenlafaxine er oral tablet extended release 24 hour 100 mg, 50 mg	Preferred	
desvenlafaxine succinate er oral tablet extended release 24 hour 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
mirtazapine oral tablet 15 mg, 30 mg, 45 mg, 7.5 mg	Preferred	90-day fill allowed after two 1-month fills
mirtazapine oral tablet dispersible 15 mg, 30 mg, 45 mg	Preferred	90-day fill allowed after two 1-month fills
phenelzine sulfate oral tablet 15 mg	Preferred	
trazodone hcl oral tablet 100 mg, 150 mg, 300 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
venlafaxine hcl er oral capsule extended release 24 hour 150 mg, 37.5 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
venlafaxine hcl er oral capsule extended release 24 hour 75 mg	Preferred	90-day fill allowed after two 1-month fills
venlafaxine hcl oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
vilazodone hcl oral tablet 10 mg, 20 mg, 40 mg	Preferred	90-day fill allowed after two 1-month fills
bupropion hcl er (xl) oral tablet extended release 24 hour 450 mg	Non Preferred	PA
nefazodone hcl oral tablet 100 mg, 150 mg, 200 mg, 250 mg, 50 mg	Non Preferred	PA
tranylcypromine sulfate oral tablet 10 mg	Non Preferred	PA
venlafaxine besylate er oral tablet extended release 24 hour 112.5 mg	Non Preferred	PA
venlafaxine hcl er oral tablet extended release 24 hour 150 mg	Non Preferred	PA; QL (1 EA per 1 day)
venlafaxine hcl er oral tablet extended release 24 hour 225 mg, 37.5 mg, 75 mg	Non Preferred	PA
APLENZIN ORAL TABLET EXTENDED RELEASE 24 HOUR 174 MG, 348 MG, 522 MG (*bupropion hbr*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG (*dextromethorphan-bupropion*)	Non Preferred	PA
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 150 MG, 37.5 MG (*venlafaxine hcl*)	Non Preferred	PA; QL (1 EA per 1 day)
EFFEXOR XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 75 MG (*venlafaxine hcl*)	Non Preferred	PA
EMSAM TRANSDERMAL PATCH 24 HOUR 12 MG/24HR, 6 MG/24HR, 9 MG/24HR (*selegiline*)	Non Preferred	PA
FETZIMA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 20 MG, 40 MG, 80 MG (*levomilnacipran hcl*)	Non Preferred	PA
FETZIMA TITRATION ORAL CAPSULE ER 24 HOUR THERAPY PACK 20 & 40 MG (*levomilnacipran hcl*)	Non Preferred	PA
FORFIVO XL ORAL TABLET EXTENDED RELEASE 24 HOUR 450 MG (*bupropion hcl*)	Non Preferred	PA
MARPLAN ORAL TABLET 10 MG (*isocarboxazid*)	Non Preferred	PA
NARDIL ORAL TABLET 15 MG (*phenelzine sulfate*)	Non Preferred	PA
PRISTIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 25 MG, 50 MG (*desvenlafaxine succinate*)	Non Preferred	PA
REMERON ORAL TABLET 15 MG, 30 MG (*mirtazapine*)	Non Preferred	PA
REMERON SOLTAB ORAL TABLET DISPERSIBLE 15 MG, 30 MG, 45 MG (*mirtazapine*)	Non Preferred	PA
TRINTELLIX ORAL TABLET 10 MG, 20 MG, 5 MG (*vortioxetine hbr*)	Non Preferred	PA
VIIBRYD ORAL TABLET 10 MG, 20 MG, 40 MG (*vilazodone hcl*)	Non Preferred	PA
WELLBUTRIN SR ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG, 150 MG, 200 MG (*bupropion hcl*)	Non Preferred	PA
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 300 MG (*bupropion hcl*)	Non Preferred	PA
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG (*zuranolone*)	Non Preferred	PA; QL (28 EA per 1 Fill); AGE (Min 18 Years)
ZURZUVAE ORAL CAPSULE 30 MG (*zuranolone*)	Non Preferred	PA; QL (14 EA per 1 Fill); AGE (Min 18 Years)
ANTIDEPRESSANTS: SSRI [OPEN CLASS]		
citalopram hydrobromide oral solution 10 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
citalopram hydrobromide oral tablet 10 mg, 20 mg, 40 mg	Preferred	90-day fill allowed after two 1-month fills
escitalopram oxalate oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
escitalopram oxalate oral tablet 20 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
fluoxetine hcl oral capsule 10 mg, 20 mg, 40 mg	Preferred	90-day fill allowed after two 1-month fills
fluoxetine hcl oral solution 20 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
fluvoxamine maleate oral tablet 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
paroxetine hcl oral tablet 10 mg, 20 mg, 30 mg, 40 mg	Preferred	90-day fill allowed after two 1-month fills
sertraline hcl oral concentrate 20 mg/ml	Preferred	90-day fill allowed after two 1-month fills
sertraline hcl oral tablet 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
citalopram hydrobromide oral capsule 30 mg	Non Preferred	PA
escitalopram oxalate oral solution 5 mg/5ml	Non Preferred	PA
fluoxetine hcl (pmdd) oral tablet 10 mg, 20 mg	Non Preferred	PA
fluoxetine hcl oral capsule delayed release 90 mg	Non Preferred	PA
fluoxetine hcl oral tablet 10 mg, 20 mg, 60 mg	Non Preferred	PA
fluvoxamine maleate er oral capsule extended release 24 hour 100 mg, 150 mg	Non Preferred	PA
paroxetine hcl er oral tablet extended release 24 hour 12.5 mg, 25 mg, 37.5 mg	Non Preferred	PA
paroxetine hcl oral suspension 10 mg/5ml	Non Preferred	PA
paroxetine mesylate oral capsule 7.5 mg	Non Preferred	PA
sertraline hcl oral capsule 150 mg, 200 mg	Non Preferred	PA
CELEXA ORAL TABLET 10 MG, 20 MG, 40 MG (*citalopram hydrobromide*)	Non Preferred	PA
LEXAPRO ORAL TABLET 10 MG, 5 MG (*escitalopram oxalate*)	Non Preferred	PA
LEXAPRO ORAL TABLET 20 MG (*escitalopram oxalate*)	Non Preferred	PA; QL (1 EA per 1 day)
PAXIL CR ORAL TABLET EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG (*paroxetine hcl*)	Non Preferred	PA
PAXIL ORAL SUSPENSION 10 MG/5ML (*paroxetine hcl*)	Non Preferred	PA
PAXIL ORAL TABLET 10 MG, 20 MG, 30 MG, 40 MG (*paroxetine hcl*)	Non Preferred	PA
PROZAC ORAL CAPSULE 10 MG, 20 MG, 40 MG (*fluoxetine hcl*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
ZOLOFT ORAL CONCENTRATE 20 MG/ML (*sertraline hcl*)	Non Preferred	PA
ZOLOFT ORAL TABLET 100 MG, 25 MG, 50 MG (*sertraline hcl*)	Non Preferred	PA
ANTIEMETIC/ANTIVERTIGO AGENTS [OPEN CLASS]		
dronabinol oral capsule 10 mg, 2.5 mg, 5 mg	Preferred	PA
ft motion sickness oral tablet 25 mg, 50 mg	Preferred	
gnp motion sickness relief oral tablet 25 mg, 50 mg	Preferred	
hm motion sickness oral tablet 50 mg	Preferred	
hm motion sickness relief oral tablet 25 mg	Preferred	
meclizine hcl oral tablet 25 mg, 50 mg	Preferred	
meclizine hcl oral tablet chewable 25 mg	Preferred	
meclizine hcl tablet 12.5 mg oral (otc)	Preferred	
meclizine hcl tablet 12.5 mg oral (rx)	Preferred	
metoclopramide hcl injection solution 5 mg/ml	Preferred	
metoclopramide hcl oral solution 10 mg/10ml, 5 mg/5ml	Preferred	
metoclopramide hcl oral tablet 10 mg, 5 mg	Preferred	
motion sickness relief oral tablet 25 mg, 50 mg	Preferred	
motion-time oral tablet chewable 25 mg	Preferred	
ondansetron hcl oral solution 4 mg/5ml	Preferred	
ondansetron hcl oral tablet 4 mg, 8 mg	Preferred	QL (60 EA per 1 Fill)
ondansetron oral tablet dispersible 16 mg, 4 mg, 8 mg	Preferred	QL (60 EA per 1 Fill)
prochlorperazine maleate oral tablet 10 mg, 5 mg	Preferred	
promethazine hcl injection solution 25 mg/ml, 50 mg/ml	Preferred	AGE (Min 2 Years)
promethazine hcl oral solution 6.25 mg/5ml	Preferred	AGE (Min 2 Years)
promethazine hcl oral tablet 12.5 mg, 25 mg, 50 mg	Preferred	AGE (Min 2 Years)
promethazine hcl rectal suppository 12.5 mg, 25 mg	Preferred	AGE (Min 2 Years)
sm motion sickness oral tablet 25 mg, 50 mg	Preferred	
trimethobenzamide hcl oral capsule 300 mg	Preferred	
DICLEGIS ORAL TABLET DELAYED RELEASE 10-10 MG (*doxylamine-pyridoxine*)	Preferred	PA; AGE (Min 18 Years)
DRIMINATE ORAL TABLET 50 MG (*dimenhydrinate*)	Preferred	
promethazine hcl (Promethegan Rectal Suppository 12.5 Mg, 25 Mg)	Preferred	AGE (Min 2 Years)
aprepitant oral 80 & 125 mg	Non Preferred	PA; QL (1 EA per 1 Fill)
aprepitant oral capsule 125 mg, 80 & 125 mg	Non Preferred	PA; QL (1 EA per 1 Fill)
aprepitant oral capsule 40 mg	Non Preferred	PA; QL (4 EA per 1 Fill)
aprepitant oral capsule 80 mg	Non Preferred	PA; QL (2 EA per 1 Fill)

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
PA - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **RX** - Prescription Drug **SP** - Specialty Drug

Drug Name	Formulary Status	Requirements/Limits
dimenhydrinate injection solution 50 mg/ml	Non Preferred	PA
doxylamine-pyridoxine oral tablet delayed release 10-10 mg	Non Preferred	PA; AGE (Min 18 Years)
focinvez intravenous solution 150 mg/50ml	Non Preferred	PA
fosaprepitant dimeglumine intravenous solution reconstituted 150 mg	Non Preferred	PA
granisetron hcl intravenous solution 1 mg/ml, 4 mg/4ml	Non Preferred	PA
granisetron hcl oral tablet 1 mg	Non Preferred	PA
ondansetron hcl injection solution 4 mg/2ml, 40 mg/20ml	Non Preferred	PA
ondansetron hcl injection solution prefilled syringe 4 mg/2ml	Non Preferred	PA
palonosetron hcl intravenous solution 0.25 mg/2ml, 0.25 mg/5ml	Non Preferred	PA
palonosetron hcl intravenous solution prefilled syringe 0.25 mg/5ml	Non Preferred	PA
prochlorperazine edisylate injection solution 10 mg/2ml, 50 mg/10ml	Non Preferred	PA; AGE (Min 2 Years)
prochlorperazine rectal suppository 25 mg	Non Preferred	PA
scopolamine transdermal patch 72 hour 1 mg/3days	Non Preferred	PA
AKYNZEO (READY-TO-USE) INTRAVENOUS SOLUTION 235-0.25 MG/20ML (*fosnetupitant-palonosetron*)	Non Preferred	PA
AKYNZEO (TO-BE-DILUTED) INTRAVENOUS SOLUTION 235-0.25 MG/20ML (*fosnetupitant-palonosetron*)	Non Preferred	PA
AKYNZEO INTRAVENOUS SOLUTION RECONSTITUTED 235-0.25 MG (*fosnetupitant-palonosetron*)	Non Preferred	PA
AKYNZEO ORAL CAPSULE 300-0.5 MG (*netupitant-palonosetron*)	Non Preferred	PA
ANTIVERT ORAL TABLET 50 MG (*meclizine hcl*)	Non Preferred	PA
ANTIVERT ORAL TABLET CHEWABLE 25 MG (*meclizine hcl*)	Non Preferred	PA
ANZEMET ORAL TABLET 50 MG (*dolasetron mesylate*)	Non Preferred	PA; QL (10 EA per 1 Fill)
APONVIE INTRAVENOUS EMULSION 32 MG/4.4ML (*aprepitant*)	Non Preferred	PA; QL (4.4 ML per 1 Fill)
BARHEMSYS INTRAVENOUS SOLUTION 10 MG/4ML, 5 MG/2ML (*amisulpride (antiemetic)*)	Non Preferred	PA
BONJESTA ORAL TABLET EXTENDED RELEASE 20-20 MG (*doxylamine-pyridoxine*)	Non Preferred	PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
CINVANTI INTRAVENOUS EMULSION 130 MG/18ML (*aprepitant*)	Non Preferred	PA; QL (36 ML per 1 Fill)
prochlorperazine (Compro Rectal Suppository 25 Mg)	Non Preferred	PA
EMEND INTRAVENOUS SOLUTION RECONSTITUTED 150 MG (*fosaprepitant dimeglumine*)	Non Preferred	PA
EMEND ORAL CAPSULE 80 MG (*aprepitant*)	Non Preferred	PA; QL (2 EA per 1 Fill)
EMEND ORAL SUSPENSION RECONSTITUTED 125 MG/5ML (*aprepitant*)	Non Preferred	PA
EMEND TRI-PACK ORAL CAPSULE 80 & 125 MG (*aprepitant*)	Non Preferred	PA; QL (1 EA per 1 Fill)
GIMOTI NASAL SOLUTION 15 MG/ACT (*metoclopramide hcl*)	Non Preferred	PA
MARINOL ORAL CAPSULE 10 MG, 2.5 MG, 5 MG (*dronabinol*)	Non Preferred	PA
PHENERGAN INJECTION SOLUTION 25 MG/ML, 50 MG/ML (*promethazine hcl*)	Non Preferred	PA; AGE (Min 2 Years)
POSFREA INTRAVENOUS SOLUTION 0.25 MG/5ML (*palonosetron hcl*)	Non Preferred	PA
PROMETHEGAN RECTAL SUPPOSITORY 50 MG (*promethazine hcl*)	Non Preferred	PA; AGE (Min 2 Years)
REGLAN ORAL TABLET 10 MG, 5 MG (*metoclopramide hcl*)	Non Preferred	PA
SANCUSO TRANSDERMAL PATCH 3.1 MG/24HR (*granisetron*)	Non Preferred	PA; QL (2 EA per 1 Fill)
SUSTOL SUBCUTANEOUS PREFILLED SYRINGE 10 MG/0.4ML (*granisetron*)	Non Preferred	PA
TIGAN INTRAMUSCULAR SOLUTION 100 MG/ML (*trimethobenzamide hcl*)	Non Preferred	PA
TRANSDERM-SCOP TRANSDERMAL PATCH 72 HOUR 1 MG/3DAYS (*scopolamine base*)	Non Preferred	PA
ANTIFUNGALS: ORAL [OPEN CLASS]		
fluconazole oral suspension reconstituted 10 mg/ml, 40 mg/ml	Preferred	90-day fill allowed after two 1-month fills
fluconazole oral tablet 100 mg, 150 mg, 200 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
griseofulvin microsize oral suspension 125 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
nystatin mouth/throat suspension 100000 unit/ml	Preferred	90-day fill allowed after two 1-month fills
nystatin oral tablet 500000 unit	Preferred	90-day fill allowed after two 1-month fills
terbinafine hcl oral tablet 250 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
clotrimazole mouth/throat troche 10 mg	Non Preferred	PA
flucytosine oral capsule 250 mg, 500 mg	Non Preferred	PA
griseofulvin microsize oral tablet 500 mg	Non Preferred	PA
griseofulvin ultramicrosize oral tablet 125 mg, 250 mg	Non Preferred	PA
itraconazole oral capsule 100 mg	Non Preferred	PA
itraconazole oral solution 10 mg/ml	Non Preferred	PA
ketoconazole oral tablet 200 mg	Non Preferred	PA
posaconazole oral suspension 40 mg/ml	Non Preferred	PA
posaconazole oral tablet delayed release 100 mg	Non Preferred	PA
tolsura oral capsule 65 mg	Non Preferred	PA
voriconazole oral suspension reconstituted 40 mg/ml	Non Preferred	PA
voriconazole oral tablet 200 mg, 50 mg	Non Preferred	PA
ANCOBON ORAL CAPSULE 250 MG, 500 MG (*flucytosine*)	Non Preferred	PA
BREXAFEMME ORAL TABLET 150 MG (*ibrexafungerp citrate*)	Non Preferred	PA
CRESEMBA ORAL CAPSULE 186 MG, 74.5 MG (*isavuconazonium sulfate*)	Non Preferred	PA
DIFLUCAN ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fluconazole*)	Non Preferred	PA
DIFLUCAN ORAL TABLET 100 MG, 200 MG (*fluconazole*)	Non Preferred	PA
NOXAFIL ORAL PACKET 300 MG (*posaconazole*)	Non Preferred	PA; AGE (Max 16 Years)
NOXAFIL ORAL SUSPENSION 40 MG/ML (*posaconazole*)	Non Preferred	PA
NOXAFIL ORAL TABLET DELAYED RELEASE 100 MG (*posaconazole*)	Non Preferred	PA
ORAVIG BUCCAL TABLET 50 MG (*miconazole*)	Non Preferred	PA
SPORANOX ORAL CAPSULE 100 MG (*itraconazole*)	Non Preferred	PA
SPORANOX ORAL SOLUTION 10 MG/ML (*itraconazole*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
VFEND ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*voriconazole*)	Non Preferred	PA
VFEND ORAL TABLET 200 MG, 50 MG (*voriconazole*)	Non Preferred	PA
VIVJOA ORAL CAPSULE THERAPY PACK 150 MG (*oteseconazole*)	Non Preferred	PA
ANTIFUNGALS: TOPICAL [OPEN CLASS]		
antifungal (clotrimazole) external cream 1 %	Preferred	
antifungal clotrimazole external cream 1 %	Preferred	
antifungal external cream 2 %	Preferred	
athletes foot (clotrimazole) external cream 1 %	Preferred	
athletes foot (terbinafine) external cream 1 %	Preferred	
ciclopirox external solution 8 %	Preferred	
clotrimazole anti-fungal external cream 1 %	Preferred	
clotrimazole cream 1 % external (otc)	Preferred	
clotrimazole cream 1 % external (rx)	Preferred	
clotrimazole solution 1 % external (otc)	Preferred	
clotrimazole solution 1 % external (rx)	Preferred	
clotrimazole-betamethasone external cream 1-0.05 %	Preferred	
ft antifungal external cream 1 %, 2 %	Preferred	
ft athletes foot (clotrimaz) external cream 1 %	Preferred	
ft athletes foot (terbinafine) external cream 1 %	Preferred	
gnp athletes foot external cream 1 %	Preferred	
gnp terbinafine hydrochloride external cream 1 %	Preferred	
gnp tolnaftate external cream 1 %	Preferred	
ketoconazole external cream 2 %	Preferred	
ketoconazole external shampoo 2 %	Preferred	
miconazole nitrate external cream 2 %	Preferred	
nystatin external cream 100000 unit/gm	Preferred	
nystatin external ointment 100000 unit/gm	Preferred	
nystatin external powder 100000 unit/gm	Preferred	
sm antifungal clotrimazole external cream 1 %	Preferred	
sm antifungal miconazole external cream 2 %	Preferred	
sm antifungal tolnaftate external cream 1 %	Preferred	
sm athletes foot external cream 1 %	Preferred	
terbinafine hcl external cream 1 %	Preferred	
tm-clotrimazole external cream 1 %	Preferred	
tolnaftate external cream 1 %	Preferred	
tolnaftate external powder 1 %	Preferred	
ciclopirox (Ciclodan External Solution 8 %)	Preferred	
MICOTRIN AC EXTERNAL CREAM 1 % (*clotrimazole*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
MYCOZYL AC EXTERNAL CREAM 1 % (*clotrimazole*)	Preferred	
nystatin (Nyamyc External Powder 100000 Unit/Gm)	Preferred	
nystatin (Nystop External Powder 100000 Unit/Gm)	Preferred	
TRIMAZOLE EXTERNAL CREAM 1 % (*clotrimazole*)	Preferred	
TRITOLNACIDE C EXTERNAL CREAM 1 % (*tolnaftate*)	Preferred	
alevazol external ointment 1 %	Non Preferred	PA
antifungal external powder 2 %	Non Preferred	PA
antifungal maximum strength external solution 1 %	Non Preferred	PA
athletes foot powder spray external aerosol powder 1 %, 2 %	Non Preferred	PA
bensal hp external ointment 3 %	Non Preferred	PA
butenafine hcl external cream 1 %	Non Preferred	PA
ciclopirox external gel 0.77 %	Non Preferred	PA
ciclopirox external shampoo 1 %	Non Preferred	PA
ciclopirox olamine external cream 0.77 %	Non Preferred	PA
ciclopirox olamine external suspension 0.77 %	Non Preferred	PA
ciclopirox treatment external kit 8 %	Non Preferred	PA
clotrimazole-betamethasone external lotion 1-0.05 %	Non Preferred	PA
econazole nitrate external cream 1 %	Non Preferred	PA
gnp miconazorb af external powder 2 %	Non Preferred	PA
ketoconazole external foam 2 %	Non Preferred	PA
luliconazole external cream 1 %	Non Preferred	PA
miconazole nitrate external solution 2 %	Non Preferred	PA
miconazole-zinc oxide-petrolat external ointment 0.25-15-81.35 %	Non Preferred	PA; AGE (Max 16 Years)
miconi-al external solution 2 %	Non Preferred	PA
naftifine hcl external cream 1 %, 2 %	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
naftifine hcl external gel 2 %	Non Preferred	PA
nystatin-triamcinolone external cream 100000-0.1 unit/gm-%	Non Preferred	PA
nystatin-triamcinolone external ointment 100000-0.1 unit/gm-%	Non Preferred	PA
oxiconazole nitrate external cream 1 %	Non Preferred	PA
tavaborole external solution 5 %	Non Preferred	PA
tm-tolnaftate external solution 1 %	Non Preferred	PA
tm-tolnaftate lr external solution 1 %	Non Preferred	PA
tolnafi-al external solution 1 %	Non Preferred	PA
votriza-al external lotion 1 %	Non Preferred	PA
ERTACZO EXTERNAL CREAM 2 % (*sertaconazole nitrate*)	Non Preferred	PA
EXTINA EXTERNAL FOAM 2 % (*ketoconazole*)	Non Preferred	PA
FUNGOID TINCTURE EXTERNAL SOLUTION 2 % (*miconazole nitrate*)	Non Preferred	PA
JUBLIA EXTERNAL SOLUTION 10 % (*efinaconazole*)	Non Preferred	PA
ketoconazole (Ketodan External Foam 2 %)	Non Preferred	PA
KETODAN EXTERNAL KIT 2 % (*ketoconazole-cleanser*)	Non Preferred	PA
LOPROX EXTERNAL CREAM 0.77 % (*ciclopirox olamine*)	Non Preferred	PA
LOPROX EXTERNAL KIT 0.77 %, 0.77 % (SUSP) (*ciclopirox olamine-cleanser*)	Non Preferred	PA
LOPROX EXTERNAL SUSPENSION 0.77 % (*ciclopirox olamine*)	Non Preferred	PA
LUZU EXTERNAL CREAM 1 % (*luliconazole*)	Non Preferred	PA
MICOMITIN EXTERNAL SOLUTION 1 % (*tolnaftate*)	Non Preferred	PA
MICOTRIN AL EXTERNAL SOLUTION 1 % (*tolnaftate*)	Non Preferred	PA
MICOTRIN AP EXTERNAL POWDER 2 % (*miconazole nitrate*)	Non Preferred	PA
MYCOZYL AL EXTERNAL SOLUTION 1 % (*tolnaftate*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
MYCOZYL AP EXTERNAL POWDER 2 % (*miconazole nitrate*)	Non Preferred	PA
NAFTIN EXTERNAL GEL 1 %, 2 % (*naftifine hcl*)	Non Preferred	PA
OXISTAT EXTERNAL LOTION 1 % (*oxiconazole nitrate*)	Non Preferred	PA
TRITOLNACIDE S EXTERNAL SOLUTION 1 % (*tolnaftate*)	Non Preferred	PA
VUSION EXTERNAL OINTMENT 0.25-15-81.35 % (*miconazole-zinc oxide-petrolat*)	Non Preferred	PA; AGE (Max 16 Years)
ANTIHYPERTENSIVES: ANGIOTENSIN MODULATOR COMBINATIONS [OPEN CLASS]		
amlodipine besy-benazepril hcl oral capsule 10-20 mg, 10-40 mg, 2.5-10 mg, 5-10 mg, 5-20 mg, 5-40 mg	Preferred	90-day fill allowed after two 1-month fills
amlodipine besylate-valsartan oral tablet 10-160 mg, 10-320 mg, 5-160 mg, 5-320 mg	Preferred	90-day fill allowed after two 1-month fills
amlodipine-olmesartan oral tablet 10-20 mg, 10-40 mg, 5-20 mg, 5-40 mg	Preferred	90-day fill allowed after two 1-month fills
aliskiren fumarate oral tablet 150 mg, 300 mg	Non Preferred	PA
amlodipine-valsartan-hctz oral tablet 10-160-12.5 mg, 10-160-25 mg, 10-320-25 mg, 5-160-12.5 mg, 5-160-25 mg	Non Preferred	PA
olmesartan-amlodipine-hctz oral tablet 20-5-12.5 mg, 40-10-12.5 mg, 40-10-25 mg, 40-5-12.5 mg, 40-5-25 mg	Non Preferred	PA
telmisartan-amlodipine oral tablet 40-10 mg, 40-5 mg, 80-10 mg, 80-5 mg	Non Preferred	PA
trandolapril-verapamil hcl er oral tablet extended release 1-240 mg, 2-180 mg, 2-240 mg, 4-240 mg	Non Preferred	PA
AZOR ORAL TABLET 10-20 MG, 10-40 MG, 5-20 MG, 5-40 MG (*amlodipine-olmesartan*)	Non Preferred	PA
EXFORGE HCT ORAL TABLET 10-160-12.5 MG, 10-160-25 MG, 10-320-25 MG, 5-160-12.5 MG, 5-160-25 MG (*amlodipine-valsartan-hctz*)	Non Preferred	PA
EXFORGE ORAL TABLET 10-160 MG, 10-320 MG, 5-160 MG, 5-320 MG (*amlodipine besylate-valsartan*)	Non Preferred	PA
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG (*amlodipine besy-benazepril hcl*)	Non Preferred	PA
TEKTURNA HCT ORAL TABLET 300-12.5 MG, 300-25 MG (*aliskiren-hydrochlorothiazide*)	Non Preferred	PA
TEKTURNA ORAL TABLET 150 MG, 300 MG (*aliskiren fumarate*)	Non Preferred	PA
TRIBENZOR ORAL TABLET 20-5-12.5 MG, 40-10-12.5 MG, 40-10-25 MG, 40-5-12.5 MG, 40-5-25 MG (*olmesartan-amlodipine-hctz*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
ANTIHYPERTENSIVES: ANGIOTENSIN MODULATORS [OPEN CLASS]		
benazepril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
benazepril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg, 5-6.25 mg	Preferred	90-day fill allowed after two 1-month fills
enalapril maleate oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
enalapril-hydrochlorothiazide oral tablet 10-25 mg, 5-12.5 mg	Preferred	90-day fill allowed after two 1-month fills
fosinopril sodium oral tablet 10 mg, 20 mg, 40 mg	Preferred	
irbesartan oral tablet 150 mg, 300 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
irbesartan-hydrochlorothiazide oral tablet 150-12.5 mg, 300-12.5 mg	Preferred	90-day fill allowed after two 1-month fills
lisinopril oral tablet 10 mg, 2.5 mg, 20 mg, 30 mg, 40 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
lisinopril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Preferred	90-day fill allowed after two 1-month fills
losartan potassium oral tablet 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
losartan potassium-hctz oral tablet 100-12.5 mg, 100-25 mg, 50-12.5 mg	Preferred	90-day fill allowed after two 1-month fills
olmesartan medoxomil oral tablet 20 mg, 40 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
olmesartan medoxomil-hctz oral tablet 20-12.5 mg, 40-12.5 mg, 40-25 mg	Preferred	90-day fill allowed after two 1-month fills
quinapril hcl oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
ramipril oral capsule 1.25 mg, 10 mg, 2.5 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
trandolapril oral tablet 1 mg, 2 mg, 4 mg	Preferred	
valsartan oral tablet 160 mg, 320 mg, 40 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
valsartan-hydrochlorothiazide oral tablet 160-12.5 mg, 160-25 mg, 320-12.5 mg, 320-25 mg, 80-12.5 mg	Preferred	90-day fill allowed after two 1-month fills
ENTRESTO ORAL TABLET 24-26 MG, 49-51 MG, 97-103 MG (*sacubitril-valsartan*)	Preferred	QL (2 EA per 1 day)
candesartan cilexetil oral tablet 16 mg, 32 mg, 4 mg, 8 mg	Non Preferred	PA
candesartan cilexetil-hctz oral tablet 16-12.5 mg, 32-12.5 mg, 32-25 mg	Non Preferred	PA
captopril oral tablet 100 mg, 12.5 mg, 25 mg, 50 mg	Non Preferred	PA
captopril-hydrochlorothiazide oral tablet 25-15 mg, 25-25 mg, 50-15 mg, 50-25 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
enalapril maleate oral solution 1 mg/ml	Non Preferred	PA
fosinopril sodium-hctz oral tablet 10-12.5 mg, 20-12.5 mg	Non Preferred	PA
moexipril hcl oral tablet 15 mg, 7.5 mg	Non Preferred	PA
perindopril erbumine oral tablet 2 mg, 4 mg, 8 mg	Non Preferred	PA
quinapril-hydrochlorothiazide oral tablet 10-12.5 mg, 20-12.5 mg, 20-25 mg	Non Preferred	PA
telmisartan oral tablet 20 mg, 40 mg, 80 mg	Non Preferred	PA
telmisartan-hctz oral tablet 40-12.5 mg, 80-12.5 mg, 80-25 mg	Non Preferred	PA
valsartan oral solution 4 mg/ml	Non Preferred	PA
ACCUPRIL ORAL TABLET 10 MG, 20 MG, 40 MG, 5 MG (*quinapril hcl*)	Non Preferred	PA
ACCURETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*quinapril-hydrochlorothiazide*)	Non Preferred	PA
ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG, 5 MG (*ramipril*)	Non Preferred	PA
ATACAND HCT ORAL TABLET 16-12.5 MG, 32-12.5 MG, 32-25 MG (*candesartan cilexetil-hctz*)	Non Preferred	PA
ATACAND ORAL TABLET 16 MG, 32 MG, 4 MG, 8 MG (*candesartan cilexetil*)	Non Preferred	PA
AVALIDE ORAL TABLET 150-12.5 MG, 300-12.5 MG (*irbesartan-hydrochlorothiazide*)	Non Preferred	PA
AVAPRO ORAL TABLET 150 MG, 300 MG, 75 MG (*irbesartan*)	Non Preferred	PA
BENICAR HCT ORAL TABLET 20-12.5 MG, 40-12.5 MG, 40-25 MG (*olmesartan medoxomil-hctz*)	Non Preferred	PA
BENICAR ORAL TABLET 20 MG, 40 MG, 5 MG (*olmesartan medoxomil*)	Non Preferred	PA
COZAAR ORAL TABLET 100 MG, 25 MG, 50 MG (*losartan potassium*)	Non Preferred	PA
DIOVAN HCT ORAL TABLET 160-12.5 MG, 160-25 MG, 320-12.5 MG, 320-25 MG, 80-12.5 MG (*valsartan-hydrochlorothiazide*)	Non Preferred	PA
DIOVAN ORAL TABLET 160 MG, 320 MG, 40 MG, 80 MG (*valsartan*)	Non Preferred	PA
EDARBI ORAL TABLET 40 MG, 80 MG (*azilsartan medoxomil*)	Non Preferred	PA
EDARBYCLOR ORAL TABLET 40-12.5 MG, 40-25 MG (*azilsartan-chlorthalidone*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
EPANED ORAL SOLUTION 1 MG/ML (*enalapril maleate*)	Non Preferred	PA
HYZAAR ORAL TABLET 100-12.5 MG, 100-25 MG, 50-12.5 MG (*losartan potassium-hctz*)	Non Preferred	PA
LOTENSIN HCT ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*benazepril-hydrochlorothiazide*)	Non Preferred	PA
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG (*benazepril hcl*)	Non Preferred	PA
MICARDIS HCT ORAL TABLET 40-12.5 MG, 80-12.5 MG, 80-25 MG (*telmisartan-hctz*)	Non Preferred	PA
MICARDIS ORAL TABLET 20 MG, 40 MG, 80 MG (*telmisartan*)	Non Preferred	PA
QBRELIS ORAL SOLUTION 1 MG/ML (*lisinopril*)	Non Preferred	PA
VASERETIC ORAL TABLET 10-25 MG (*enalapril-hydrochlorothiazide*)	Non Preferred	PA
VASOTEC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (*enalapril maleate*)	Non Preferred	PA
ZESTORETIC ORAL TABLET 10-12.5 MG, 20-12.5 MG, 20-25 MG (*lisinopril-hydrochlorothiazide*)	Non Preferred	PA
ZESTRIL ORAL TABLET 10 MG, 2.5 MG, 20 MG, 30 MG, 40 MG, 5 MG (*lisinopril*)	Non Preferred	PA
ANTIHYPERTENSIVES: BETA BLOCKERS [OPEN CLASS]		
acebutolol hcl oral capsule 200 mg, 400 mg	Preferred	
atenolol oral tablet 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
atenolol-chlorthalidone oral tablet 100-25 mg, 50-25 mg	Preferred	
bisoprolol fumarate oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
bisoprolol-hydrochlorothiazide oral tablet 10-6.25 mg, 2.5-6.25 mg, 5-6.25 mg	Preferred	
carvedilol oral tablet 12.5 mg, 25 mg, 3.125 mg, 6.25 mg	Preferred	90-day fill allowed after two 1-month fills
labetalol hcl oral tablet 100 mg, 200 mg, 300 mg	Preferred	90-day fill allowed after two 1-month fills
metoprolol succinate er oral tablet extended release 24 hour 100 mg, 200 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
metoprolol tartrate oral tablet 100 mg, 25 mg, 37.5 mg, 50 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
metoprolol-hydrochlorothiazide oral tablet 100-25 mg, 100-50 mg, 50-25 mg	Preferred	
propranolol hcl er oral capsule extended release 24 hour 120 mg, 160 mg, 60 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
propranolol hcl oral solution 20 mg/5ml, 40 mg/5ml	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
propranolol hcl oral tablet 10 mg, 20 mg, 40 mg, 60 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
propranolol-hctz oral tablet 40-25 mg, 80-25 mg	Preferred	
sotalol hcl (af) oral tablet 120 mg	Preferred	
sotalol hcl (af) oral tablet 160 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
sotalol hcl oral tablet 120 mg, 160 mg, 240 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
sotalol hcl (Sorine Oral Tablet 120 Mg, 160 Mg, 240 Mg, 80 Mg)	Preferred	90-day fill allowed after two 1-month fills
betaxolol hcl oral tablet 10 mg, 20 mg	Non Preferred	PA
carvedilol phosphate er oral capsule extended release 24 hour 10 mg, 20 mg, 40 mg, 80 mg	Non Preferred	PA
nadolol oral tablet 20 mg, 40 mg, 80 mg	Non Preferred	PA
nebivolol hcl oral tablet 10 mg, 2.5 mg, 20 mg, 5 mg	Non Preferred	PA
pindolol oral tablet 10 mg, 5 mg	Non Preferred	PA
timolol maleate oral tablet 10 mg, 20 mg, 5 mg	Non Preferred	PA
BETAPACE AF ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl af*)	Non Preferred	PA
BETAPACE ORAL TABLET 120 MG, 160 MG, 80 MG (*sotalol hcl*)	Non Preferred	PA
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG, 20 MG, 5 MG (*nebivolol hcl*)	Non Preferred	PA
COREG CR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 40 MG, 80 MG (*carvedilol phosphate*)	Non Preferred	PA
COREG ORAL TABLET 12.5 MG, 25 MG, 3.125 MG, 6.25 MG (*carvedilol*)	Non Preferred	PA
CORGARD ORAL TABLET 20 MG, 40 MG (*nadolol*)	Non Preferred	PA
HEMANGEOL ORAL SOLUTION 4.28 MG/ML (*propranolol hcl*)	Non Preferred	PA; AGE (Max 1 Years)
INDERAL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 160 MG, 60 MG, 80 MG (*propranolol hcl*)	Non Preferred	PA
INDERAL XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (*propranolol hcl sr beads*)	Non Preferred	PA
INNOPRAN XL ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 80 MG (*propranolol hcl sr beads*)	Non Preferred	PA
KAPSPARGO SPRINKLE ORAL CAPSULE ER 24 HOUR SPRINKLE 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*)	Non Preferred	PA
LOPRESSOR ORAL TABLET 100 MG, 50 MG (*metoprolol tartrate*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
SOTYLIZE ORAL SOLUTION 5 MG/ML (*sotalol hcl*)	Non Preferred	PA
TENORETIC 100 ORAL TABLET 100-25 MG (*atenolol-chlorthalidone*)	Non Preferred	PA
TENORETIC 50 ORAL TABLET 50-25 MG (*atenolol-chlorthalidone*)	Non Preferred	PA
TENORMIN ORAL TABLET 100 MG, 25 MG, 50 MG (*atenolol*)	Non Preferred	PA
TOPROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 25 MG, 50 MG (*metoprolol succinate*)	Non Preferred	PA
ZIAC ORAL TABLET 10-6.25 MG, 2.5-6.25 MG, 5-6.25 MG (*bisoprolol-hydrochlorothiazide*)	Non Preferred	PA
ANTIHYPERTENSIVES: CALCIUM CHANNEL BLOCKERS [OPEN CLASS]		
amlodipine besylate oral tablet 10 mg, 2.5 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er coated beads oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg, 300 mg, 360 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er oral capsule extended release 12 hour 120 mg, 60 mg, 90 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er oral tablet extended release 24 hour 180 mg, 240 mg, 300 mg, 360 mg, 420 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl oral tablet 120 mg, 30 mg, 60 mg, 90 mg	Preferred	90-day fill allowed after two 1-month fills
dilt-xr oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	Preferred	90-day fill allowed after two 1-month fills
felodipine er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	Preferred	
nifedipine er oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	Preferred	90-day fill allowed after two 1-month fills
nifedipine er osmotic release oral tablet extended release 24 hour 30 mg, 60 mg, 90 mg	Preferred	90-day fill allowed after two 1-month fills
nifedipine oral capsule 10 mg, 20 mg	Preferred	90-day fill allowed after two 1-month fills
verapamil hcl er oral capsule extended release 24 hour 120 mg, 180 mg, 240 mg	Preferred	
verapamil hcl er oral tablet extended release 120 mg, 180 mg, 240 mg	Preferred	90-day fill allowed after two 1-month fills
verapamil hcl oral tablet 120 mg, 40 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl coated beads (Cartia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
diltiazem hcl er beads (Taztia Xt Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg)	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er beads (Tiadylt Er Oral Capsule Extended Release 24 Hour 120 Mg, 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Preferred	90-day fill allowed after two 1-month fills
diltiazem hcl er oral tablet extended release 24 hour 120 mg	Non Preferred	PA
isradipine oral capsule 2.5 mg, 5 mg	Non Preferred	PA
levamlodipine maleate oral tablet 2.5 mg, 5 mg	Non Preferred	PA
nicardipine hcl oral capsule 20 mg, 30 mg	Non Preferred	PA
nisoldipine er oral tablet extended release 24 hour 17 mg, 20 mg, 25.5 mg, 30 mg, 34 mg, 40 mg, 8.5 mg	Non Preferred	PA
verapamil hcl er oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg, 360 mg	Non Preferred	PA
CARDIZEM CD ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG (*diltiazem hcl coated beads*)	Non Preferred	PA
CARDIZEM LA ORAL TABLET EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl*)	Non Preferred	PA
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG (*diltiazem hcl*)	Non Preferred	PA
KATERZIA ORAL SUSPENSION 1 MG/ML (*amlodipine benzoate*)	Non Preferred	PA
diltiazem hcl (Matzim La Oral Tablet Extended Release 24 Hour 180 Mg, 240 Mg, 300 Mg, 360 Mg, 420 Mg)	Non Preferred	PA
NORLIQVA ORAL SOLUTION 1 MG/ML (*amlodipine besylate*)	Non Preferred	PA
NORVASC ORAL TABLET 10 MG, 2.5 MG, 5 MG (*amlodipine besylate*)	Non Preferred	PA
PROCARDIA XL ORAL TABLET EXTENDED RELEASE 24 HOUR 30 MG, 60 MG, 90 MG (*nifedipine*)	Non Preferred	PA
SULAR ORAL TABLET EXTENDED RELEASE 24 HOUR 17 MG, 34 MG, 8.5 MG (*nisoldipine*)	Non Preferred	PA
TIAZAC ORAL CAPSULE EXTENDED RELEASE 24 HOUR 120 MG, 180 MG, 240 MG, 300 MG, 360 MG, 420 MG (*diltiazem hcl er beads*)	Non Preferred	PA
VERELAN PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (*verapamil hcl*)	Non Preferred	PA
ANTIHYPERTENSIVES: SYMPATHOLYTICS [OPEN CLASS]		
clonidine hcl oral tablet 0.1 mg, 0.2 mg, 0.3 mg	Preferred	90-day fill allowed after two 1-month fills
clonidine transdermal patch weekly 0.1 mg/24hr, 0.2 mg/24hr, 0.3 mg/24hr	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
guanfacine hcl oral tablet 1 mg, 2 mg	Preferred	90-day fill allowed after two 1-month fills
methyldopa oral tablet 250 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
clonidine hcl er oral tablet extended release 24 hour 0.17 mg	Non Preferred	PA
methyldopa-hydrochlorothiazide oral tablet 250-15 mg, 250-25 mg	Non Preferred	PA
ANTIHYPERURICEMICS [OPEN CLASS]		
allopurinol oral tablet 100 mg, 300 mg	Preferred	90-day fill allowed after two 1-month fills
colchicine oral capsule 0.6 mg	Preferred	
colchicine oral tablet 0.6 mg	Preferred	90-day fill allowed after two 1-month fills
colchicine-probenecid oral tablet 0.5-500 mg	Preferred	90-day fill allowed after two 1-month fills
probenecid oral tablet 500 mg	Preferred	90-day fill allowed after two 1-month fills
allopurinol oral tablet 200 mg	Non Preferred	PA
febuxostat oral tablet 40 mg, 80 mg	Non Preferred	PA
COLCRYS ORAL TABLET 0.6 MG (*colchicine*)	Non Preferred	PA
GLOPERBA ORAL SOLUTION 0.6 MG/5ML (*colchicine*)	Non Preferred	PA
MITIGARE ORAL CAPSULE 0.6 MG (*colchicine*)	Non Preferred	PA
ULORIC ORAL TABLET 40 MG, 80 MG (*febuxostat*)	Non Preferred	PA
ZYLOPRIM ORAL TABLET 100 MG (*allopurinol*)	Non Preferred	PA
ANTIMIGRAINE AGENTS [OPEN CLASS]		
rizatriptan benzoate oral tablet 10 mg, 5 mg	Preferred	QL (12 EA per 1 Fill)
rizatriptan benzoate oral tablet dispersible 10 mg, 5 mg	Preferred	QL (12 EA per 1 Fill)
sumatriptan nasal solution 20 mg/act, 5 mg/act	Preferred	QL (6 EA per 30 days)
sumatriptan succinate oral tablet 100 mg	Preferred	QL (9 EA per 1 Fill)
sumatriptan succinate oral tablet 25 mg, 50 mg	Preferred	QL (18 EA per 1 Fill)
sumatriptan succinate refill subcutaneous solution cartridge 4 mg/0.5ml, 6 mg/0.5ml	Preferred	QL (2 ML per 30 days)
sumatriptan succinate subcutaneous solution 6 mg/0.5ml	Preferred	QL (1 ML per 30 days)
sumatriptan succinate subcutaneous solution auto-injector 4 mg/0.5ml, 6 mg/0.5ml	Preferred	QL (2 ML per 30 days)
IMITREX NASAL SOLUTION 20 MG/ACT, 5 MG/ACT (*sumatriptan*)	Preferred	QL (6 EA per 30 days)

Drug Name	Formulary Status	Requirements/Limits
almotriptan malate oral tablet 12.5 mg, 6.25 mg	Non Preferred	PA; QL (6 EA per 1 Fill)
eletriptan hydrobromide oral tablet 20 mg, 40 mg	Non Preferred	PA; QL (6 EA per 1 Fill)
frovatriptan succinate oral tablet 2.5 mg	Non Preferred	PA; QL (12 EA per 1 Fill)
naratriptan hcl oral tablet 1 mg, 2.5 mg	Non Preferred	PA; QL (9 EA per 1 Fill)
sumatriptan-naproxen sodium oral tablet 85-500 mg	Non Preferred	PA
zolmitriptan nasal solution 2.5 mg	Non Preferred	PA; QL (6 EA per 1 Fill)
zolmitriptan nasal solution 5 mg	Non Preferred	PA
zolmitriptan oral tablet 2.5 mg, 5 mg	Non Preferred	PA; QL (8 EA per 1 Fill)
zolmitriptan oral tablet dispersible 2.5 mg, 5 mg	Non Preferred	PA; QL (8 EA per 1 Fill)
FROVA ORAL TABLET 2.5 MG (*frovatriptan succinate*)	Non Preferred	PA; QL (12 EA per 1 Fill)
IMITREX ORAL TABLET 100 MG (*sumatriptan succinate*)	Non Preferred	PA; QL (9 EA per 1 Fill)
IMITREX ORAL TABLET 25 MG, 50 MG (*sumatriptan succinate*)	Non Preferred	PA; QL (18 EA per 1 Fill)
IMITREX STATDOSE REFILL SUBCUTANEOUS SOLUTION CARTRIDGE 4 MG/0.5ML, 6 MG/0.5ML (*sumatriptan succinate*)	Non Preferred	PA; QL (2 ML per 30 days)
IMITREX STATDOSE SYSTEM SUBCUTANEOUS SOLUTION AUTO-INJECTOR 4 MG/0.5ML, 6 MG/0.5ML (*sumatriptan succinate*)	Non Preferred	PA; QL (2 ML per 30 days)
MAXALT ORAL TABLET 10 MG (*rizatriptan benzoate*)	Non Preferred	PA; QL (12 EA per 1 Fill)
MAXALT-MLT ORAL TABLET DISPERSIBLE 10 MG (*rizatriptan benzoate*)	Non Preferred	PA; QL (12 EA per 1 Fill)
RELPAX ORAL TABLET 20 MG, 40 MG (*eletriptan hydrobromide*)	Non Preferred	PA; QL (6 EA per 1 Fill)
TOSYMRA NASAL SOLUTION 10 MG/ACT (*sumatriptan*)	Non Preferred	PA; QL (6 EA per 30 days)
ZEMBRACE SYMTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 3 MG/0.5ML (*sumatriptan succinate*)	Non Preferred	PA
ZOMIG NASAL SOLUTION 2.5 MG (*zolmitriptan*)	Non Preferred	PA; QL (6 EA per 1 Fill)
ZOMIG NASAL SOLUTION 5 MG (*zolmitriptan*)	Non Preferred	PA
zolmitriptan (Zomig Oral Tablet 2.5 Mg, 5 Mg)	Non Preferred	PA; QL (8 EA per 1 Fill)

Drug Name	Formulary Status	Requirements/Limits
ANTIMIGRAINE AGENTS: OTHERS [CLOSED CLASS]		
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML (*erenumab-aooe*)	Preferred	PA (Eligible for auto-PA approval); QL (1 ML per 30 days); AGE (Min 18 Years)
AJOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 225 MG/1.5ML (*fremanezumab-vfrm*)	Preferred	PA (Eligible for auto-PA approval); QL (1.5 ML per 30 days); AGE (Min 18 Years)
AJOVY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 225 MG/1.5ML (*fremanezumab-vfrm*)	Preferred	PA (Eligible for auto-PA approval); QL (1.5 ML per 30 days); AGE (Min 18 Years)
EMGALITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 120 MG/ML (*galcanezumab-gnlm*)	Preferred	PA (Eligible for auto-PA approval); QL (1 ML per 30 days); AGE (Min 18 Years)
EMGALITY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*galcanezumab-gnlm*)	Preferred	PA (Eligible for auto-PA approval); QL (1 ML per 30 days); AGE (Min 18 Years)
NURTEC ORAL TABLET DISPERSIBLE 75 MG (*rimegepant sulfate*)	Preferred	PA (Eligible for auto-PA approval); QL (16 EA per 30 days); AGE (Min 18 Years)
QULIPTA ORAL TABLET 10 MG, 30 MG, 60 MG (*atogepant*)	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
UBRELVY ORAL TABLET 100 MG, 50 MG (*ubrogepant*)	Preferred	PA (Eligible for auto-PA approval); QL (16 EA per 30 days); AGE (Min 18 Years)
EMGALITY (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*galcanezumab-gnlm*)	Non Preferred	PA; QL (1 ML per 30 days); AGE (Min 18 Years)
REYVOW ORAL TABLET 100 MG, 50 MG (*lasmiditan succinate*)	Non Preferred	PA; QL (8 EA per 30 days); AGE (Min 18 Years)
VYEPTI INTRAVENOUS SOLUTION 100 MG/ML (*eptinezumab-jjmr*)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZAVZPRET NASAL SOLUTION 10 MG/ACT (*zavegepant hcl*)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: ATYPICAL [CLOSED CLASS]		
aripiprazole oral tablet 10 mg, 15 mg, 2 mg, 20 mg, 30 mg, 5 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
clozapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	Preferred	AGE (Min 18 Years)
lurasidone hcl oral tablet 120 mg, 20 mg, 40 mg, 60 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
lurasidone hcl oral tablet 80 mg	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
olanzapine intramuscular solution reconstituted 10 mg	Preferred	AGE (Min 18 Years)
olanzapine oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 5 mg, 7.5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
olanzapine oral tablet dispersible 10 mg, 15 mg, 20 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
quetiapine fumarate er oral tablet extended release 24 hour 150 mg, 200 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
quetiapine fumarate er oral tablet extended release 24 hour 300 mg, 400 mg, 50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
quetiapine fumarate oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
quetiapine fumarate oral tablet 150 mg	Preferred	AGE (Min 18 Years)
risperidone oral solution 1 mg/ml	Preferred	QL (2 ML per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
risperidone oral tablet dispersible 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
ziprasidone hcl oral capsule 20 mg, 40 mg, 60 mg, 80 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
VRAYLAR ORAL CAPSULE 1.5 MG, 3 MG, 4.5 MG, 6 MG (*cariprazine hcl*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
VRAYLAR ORAL CAPSULE THERAPY PACK 1.5 & 3 MG (*cariprazine hcl*)	Preferred	AGE (Min 18 Years)
aripiprazole oral solution 1 mg/ml	Non Preferred	PA; AGE (Min 18 Years)
aripiprazole oral tablet dispersible 10 mg, 15 mg	Non Preferred	PA; AGE (Min 18 Years)
asenapine maleate sublingual tablet sublingual 10 mg, 2.5 mg, 5 mg	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
clozapine oral tablet dispersible 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg	Non Preferred	PA; AGE (Min 18 Years)
olanzapine-fluoxetine hcl oral capsule 12-25 mg, 12-50 mg, 3-25 mg, 6-25 mg, 6-50 mg	Non Preferred	PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
paliperidone er oral tablet extended release 24 hour 1.5 mg, 3 mg, 6 mg, 9 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
ziprasidone mesylate intramuscular solution reconstituted 20 mg	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY MYCITE STARTER KIT ORAL TABLET THERAPY PACK 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (*aripiprazole w/ sens-strip-pod*)	Non Preferred	PA; AGE (Min 18 Years)
ABILIFY ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG (*aripiprazole*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
CAPLYTA ORAL CAPSULE 10.5 MG, 21 MG, 42 MG (*lumateperone tosylate*)	Non Preferred	PA; AGE (Min 18 Years)
CLOZARIL ORAL TABLET 100 MG, 25 MG (*clozapine*)	Non Preferred	PA; AGE (Min 18 Years)
FANAPT ORAL TABLET 1 MG, 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG (*iloperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
FANAPT TITRATION PACK ORAL TABLET 1 & 2 & 4 & 6 MG (*iloperidone*)	Non Preferred	PA; AGE (Min 18 Years)
GEODON INTRAMUSCULAR SOLUTION RECONSTITUTED 20 MG (*ziprasidone mesylate*)	Non Preferred	PA; AGE (Min 18 Years)
GEODON ORAL CAPSULE 20 MG, 40 MG, 60 MG, 80 MG (*ziprasidone hcl*)	Non Preferred	PA; AGE (Min 18 Years)
INVEGA ORAL TABLET EXTENDED RELEASE 24 HOUR 3 MG, 6 MG, 9 MG (*paliperidone*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG (*lurasidone hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LATUDA ORAL TABLET 80 MG (*lurasidone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
LYBALVI ORAL TABLET 10-10 MG, 15-10 MG, 20-10 MG, 5-10 MG (*olanzapine-samidorphan*)	Non Preferred	PA; AGE (Min 18 Years)
NUPLAZID ORAL CAPSULE 34 MG (*pimavanserin tartrate*)	Non Preferred	SP; PA; QL (2 EA per 1 day); AGE (Min 18 Years)
NUPLAZID ORAL TABLET 10 MG (*pimavanserin tartrate*)	Non Preferred	SP; PA; QL (2 EA per 1 day); AGE (Min 18 Years)
REXULTI ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (*brexpiprazole*)	Non Preferred	PA; AGE (Min 18 Years)
RISPERDAL ORAL SOLUTION 1 MG/ML (*risperidone*)	Non Preferred	PA; QL (2 ML per 1 day); AGE (Min 18 Years)
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG, 4 MG (*risperidone*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SAPHRIS SUBLINGUAL TABLET SUBLINGUAL 10 MG, 2.5 MG, 5 MG (*asenapine maleate*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
SECUADO TRANSDERMAL PATCH 24 HOUR 3.8 MG/24HR, 5.7 MG/24HR, 7.6 MG/24HR (*asenapine*)	Non Preferred	PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 400 MG, 50 MG (*quetiapine fumarate*)	Non Preferred	PA; AGE (Min 18 Years)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150 MG, 200 MG (*quetiapine fumarate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HOUR 300 MG, 400 MG, 50 MG (*quetiapine fumarate*)	Non Preferred	PA; AGE (Min 18 Years)
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG (*olanzapine-fluoxetine hcl*)	Non Preferred	PA; AGE (Min 18 Years)
VERSACLOZ ORAL SUSPENSION 50 MG/ML (*clozapine*)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA INTRAMUSCULAR SOLUTION RECONSTITUTED 10 MG (*olanzapine*)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA ORAL TABLET 10 MG, 15 MG, 2.5 MG, 20 MG, 5 MG, 7.5 MG (*olanzapine*)	Non Preferred	PA; AGE (Min 18 Years)
ZYPREXA ZYDIS ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 20 MG, 5 MG (*olanzapine*)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: ATYPICAL, LONG-ACTING INJECTABLE [CLOSED CLASS]		
ABILIFY ASIMTUFII INTRAMUSCULAR PREFILLED SYRINGE 720 MG/2.4ML, 960 MG/3.2ML (*aripiprazole*)	Preferred	AGE (Min 18 Years); Max 60-day supply per 1 Fill
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE 300 MG, 400 MG (*aripiprazole*)	Preferred	AGE (Min 18 Years)
ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 300 MG, 400 MG (*aripiprazole*)	Preferred	AGE (Min 18 Years)
ARISTADA INITIO INTRAMUSCULAR PREFILLED SYRINGE 675 MG/2.4ML (*aripiprazole lauroxil*)	Preferred	AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 1064 MG/3.9ML (*aripiprazole lauroxil*)	Preferred	AGE (Min 18 Years); Max 60-day supply per 1 Fill
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 441 MG/1.6ML, 662 MG/2.4ML (*aripiprazole lauroxil*)	Preferred	AGE (Min 18 Years)
ARISTADA INTRAMUSCULAR PREFILLED SYRINGE 882 MG/3.2ML (*aripiprazole lauroxil*)	Preferred	AGE (Min 18 Years); Max 42-day supply per 1 Fill
INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML (*paliperidone palmitate*)	Preferred	AGE (Min 18 Years); Max 180-day supply per 1 Fill
INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML (*paliperidone palmitate*)	Preferred	AGE (Min 18 Years)
INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML, 410 MG/1.32ML, 546 MG/1.75ML, 819 MG/2.63ML (*paliperidone palmitate*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
PERSERIS SUBCUTANEOUS PREFILLED SYRINGE 120 MG, 90 MG (*risperidone*)	Preferred	AGE (Min 18 Years)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG, 50 MG (*risperidone microspheres*)	Preferred	QL (2 EA per 28 days); AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 100 MG/0.28ML, 150 MG/0.42ML, 200 MG/0.56ML, 250 MG/0.7ML (*risperidone*)	Preferred	AGE (Min 18 Years); Max 60-day supply per 1 Fill
UZEDY SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 125 MG/0.35ML, 50 MG/0.14ML, 75 MG/0.21ML (*risperidone*)	Preferred	AGE (Min 18 Years)
risperidone microspheres er intramuscular suspension reconstituted er 12.5 mg, 25 mg, 37.5 mg, 50 mg	Non Preferred	PA; QL (2 EA per 28 days); AGE (Min 18 Years)
RYKINDO INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 25 MG, 37.5 MG, 50 MG (*risperidone*)	Non Preferred	PA; QL (2 EA per 28 days); AGE (Min 18 Years)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG, 300 MG, 405 MG (*olanzapine pamoate*)	Non Preferred	PA; AGE (Min 18 Years)
ANTIPSYCHOTICS: TYPICAL [CLOSED CLASS]		
chlorpromazine hcl injection solution 25 mg/ml, 50 mg/2ml	Preferred	AGE (Min 18 Years)
chlorpromazine hcl oral concentrate 100 mg/ml, 30 mg/ml	Preferred	AGE (Min 18 Years)
chlorpromazine hcl oral tablet 10 mg, 100 mg, 200 mg, 25 mg, 50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
fluphenazine decanoate injection solution 25 mg/ml	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
fluphenazine hcl injection solution 2.5 mg/ml	Preferred	AGE (Min 18 Years)
fluphenazine hcl oral concentrate 5 mg/ml	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
fluphenazine hcl oral elixir 2.5 mg/5ml	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
fluphenazine hcl oral tablet 1 mg, 10 mg, 2.5 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
haloperidol lactate injection solution 5 mg/ml	Preferred	AGE (Min 18 Years)
haloperidol lactate oral concentrate 2 mg/ml	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
haloperidol oral tablet 0.5 mg, 1 mg, 10 mg, 2 mg, 20 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
loxapine succinate oral capsule 10 mg, 25 mg, 5 mg, 50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
perphenazine oral tablet 16 mg, 2 mg, 4 mg, 8 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
perphenazine-amitriptyline oral tablet 2-10 mg, 2-25 mg, 4-10 mg, 4-25 mg, 4-50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
thioridazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
thiothixene oral capsule 1 mg, 10 mg, 2 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
trifluoperazine hcl oral tablet 1 mg, 10 mg, 2 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
molindone hcl oral tablet 10 mg, 25 mg, 5 mg	Non Preferred	PA; AGE (Min 18 Years)
pimozide oral tablet 1 mg, 2 mg	Non Preferred	PA; AGE (Min 18 Years)
ADASUVE INHALATION AEROSOL POWDER BREATH ACTIVATED 10 MG (*loxapine*)	Non Preferred	PA; AGE (Min 18 Years)
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/ML (*haloperidol decanoate*)	Non Preferred	PA; AGE (Min 18 Years)
BENIGN PROSTATIC HYPERTROPHY (BPH) [OPEN CLASS]		
alfuzosin hcl er oral tablet extended release 24 hour 10 mg	Preferred	90-day fill allowed after two 1-month fills
dutasteride oral capsule 0.5 mg	Preferred	90-day fill allowed after two 1-month fills
finasteride oral tablet 5 mg	Preferred	90-day fill allowed after two 1-month fills
tamsulosin hcl oral capsule 0.4 mg	Preferred	90-day fill allowed after two 1-month fills
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML (*benralizumab*)	Preferred	SP; PA; AGE (Min 6 Years)
dutasteride-tamsulosin hcl oral capsule 0.5-0.4 mg	Non Preferred	PA
silodosin oral capsule 4 mg, 8 mg	Non Preferred	PA
tadalafil oral tablet 2.5 mg, 5 mg	Non Preferred	PA; AGE (Min 18 Years)
AVODART ORAL CAPSULE 0.5 MG (*dutasteride*)	Non Preferred	PA
CIALIS ORAL TABLET 5 MG (*tadalafil*)	Non Preferred	PA; AGE (Min 18 Years)
ENTADFI ORAL CAPSULE 5-5 MG (*finasteride-tadalafil*)	Non Preferred	PA; AGE (Min 18 Years)
FLOMAX ORAL CAPSULE 0.4 MG (*tamsulosin hcl*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
PROSCAR ORAL TABLET 5 MG (*finasteride*)	Non Preferred	PA
RAPAFLO ORAL CAPSULE 4 MG, 8 MG (*silodosin*)	Non Preferred	PA
BILE SALTS [OPEN CLASS]		
ursodiol oral capsule 300 mg	Preferred	90-day fill allowed after two 1-month fills
ursodiol oral tablet 250 mg	Preferred	90-day fill allowed after two 1-month fills
ursodiol oral tablet 500 mg	Preferred	
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 200 MCG (*odevixibat*)	Non Preferred	SP; PA; QL (36 EA per 1 day)
BYLVAY (PELLETS) ORAL CAPSULE SPRINKLE 600 MCG (*odevixibat*)	Non Preferred	SP; PA; QL (12 EA per 1 day)
BYLVAY ORAL CAPSULE 1200 MCG (*odevixibat*)	Non Preferred	SP; PA; QL (6 EA per 1 day)
BYLVAY ORAL CAPSULE 400 MCG (*odevixibat*)	Non Preferred	SP; PA; QL (18 EA per 1 day)
CHENODAL ORAL TABLET 250 MG (*chenodiol*)	Non Preferred	SP; PA
CHOLBAM ORAL CAPSULE 250 MG, 50 MG (*cholic acid*)	Non Preferred	SP; PA
IQIRVO ORAL TABLET 80 MG (*elafibranor*)	Non Preferred	PA
LIVMARLI ORAL SOLUTION 19 MG/ML (*maralixibat chloride*)	Non Preferred	PA
LIVMARLI ORAL SOLUTION 9.5 MG/ML (*maralixibat chloride*)	Non Preferred	SP; PA
OCALIVA ORAL TABLET 10 MG, 5 MG (*obeticholic acid*)	Non Preferred	SP; PA
RELTONE ORAL CAPSULE 200 MG, 400 MG (*ursodiol*)	Non Preferred	PA
URSO 250 ORAL TABLET 250 MG (*ursodiol*)	Non Preferred	PA
URSO FORTE ORAL TABLET 500 MG (*ursodiol*)	Non Preferred	PA
BONE RESORPTION SUPPRESSION: BISPHOSPHONATES [OPEN CLASS]		
alendronate sodium oral tablet 10 mg, 35 mg, 70 mg	Preferred	90-day fill allowed after two 1-month fills
ibandronate sodium oral tablet 150 mg	Preferred	90-day fill allowed after two 1-month fills
alendronate sodium oral solution 70 mg/75ml	Non Preferred	PA
risedronate sodium oral tablet 150 mg, 30 mg, 35 mg, 5 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
risedronate sodium oral tablet delayed release 35 mg	Non Preferred	PA
ACTONEL ORAL TABLET 150 MG, 35 MG (*risedronate sodium*)	Non Preferred	PA
ATELVIA ORAL TABLET DELAYED RELEASE 35 MG (*risedronate sodium*)	Non Preferred	PA
BINOSTO ORAL TABLET EFFERVESCENT 70 MG (*alendronate sodium*)	Non Preferred	PA
FOSAMAX ORAL TABLET 70 MG (*alendronate sodium*)	Non Preferred	PA
FOSAMAX PLUS D ORAL TABLET 70-2800 MG-UNIT, 70-5600 MG-UNIT (*alendronate-cholecalciferol*)	Non Preferred	PA
BONE RESORPTION SUPPRESSION: CALCITONINS [OPEN CLASS]		
calcitonin (salmon) nasal solution 200 unit/act	Preferred	90-day fill allowed after two 1-month fills
BONE RESORPTION SUPPRESSION: OTHER [OPEN CLASS]		
raloxifene hcl oral tablet 60 mg	Preferred	90-day fill allowed after two 1-month fills
teriparatide subcutaneous solution pen-injector 600 mcg/2.4ml	Non Preferred	SP; PA
EVISTA ORAL TABLET 60 MG (*raloxifene hcl*)	Non Preferred	PA
TYMLOS SUBCUTANEOUS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML (*abaloparatide*)	Non Preferred	SP; PA
BRONCHODILATORS: LONG ACTING BETA ADRENERGICS (LABA) [OPEN CLASS]		
SEREVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*salmeterol xinafoate*)	Preferred	90-day fill allowed after two 1-month fills
STRIVERDI RESPIMAT INHALATION AEROSOL SOLUTION 2.5 MCG/ACT (*olodaterol hcl*)	Preferred	
arformoterol tartrate inhalation nebulization solution 15 mcg/2ml	Non Preferred	PA
formoterol fumarate inhalation nebulization solution 20 mcg/2ml	Non Preferred	PA
BROVANA INHALATION NEBULIZATION SOLUTION 15 MCG/2ML (*arformoterol tartrate*)	Non Preferred	PA
PERFOROMIST INHALATION NEBULIZATION SOLUTION 20 MCG/2ML (*formoterol fumarate*)	Non Preferred	PA
BRONCHODILATORS: SHORT ACTING BETA ADRENERGIC [OPEN CLASS]		
albuterol sulfate hfa inhalation aerosol solution 108 (90 base) mcg/act	Preferred	90-day fill allowed after two 1-month fills
albuterol sulfate inhalation nebulization solution (2.5 mg/3ml) 0.083%, 0.63 mg/3ml, 1.25 mg/3ml	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
albuterol sulfate inhalation nebulization solution (5 mg/ml) 0.5%, 2.5 mg/0.5ml	Preferred	
PROAIR RESPICLICK INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (*albuterol sulfate*)	Preferred	90-day fill allowed after two 1-month fills
VENTOLIN HFA INHALATION AEROSOL SOLUTION 108 (90 BASE) MCG/ACT (*albuterol sulfate*)	Preferred	90-day fill allowed after two 1-month fills
levalbuterol hcl inhalation nebulization solution 0.31 mg/3ml, 0.63 mg/3ml, 1.25 mg/0.5ml, 1.25 mg/3ml	Non Preferred	PA
levalbuterol tartrate inhalation aerosol 45 mcg/act	Non Preferred	PA
PROAIR DIGIHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 108 (90 BASE) MCG/ACT (*albuterol sulfate (sensor)*)	Non Preferred	PA
XOPENEX HFA INHALATION AEROSOL 45 MCG/ACT (*levalbuterol tartrate*)	Non Preferred	PA
CEPHALOSPORINS: ORAL [OPEN CLASS]		
cefaclor oral capsule 250 mg, 500 mg	Preferred	
cefdinir oral capsule 300 mg	Preferred	
cefdinir oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Preferred	
cefprozil oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Preferred	
cefprozil oral tablet 250 mg, 500 mg	Preferred	
cefuroxime axetil oral tablet 250 mg, 500 mg	Preferred	
cefaclor er oral tablet extended release 12 hour 500 mg	Non Preferred	PA
cefaclor oral suspension reconstituted 125 mg/5ml, 375 mg/5ml	Non Preferred	PA
cefixime oral capsule 400 mg	Non Preferred	PA
cefixime oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	Non Preferred	PA
cefpodoxime proxetil oral suspension reconstituted 100 mg/5ml, 50 mg/5ml	Non Preferred	PA
cefpodoxime proxetil oral tablet 100 mg, 200 mg	Non Preferred	PA
COLONY STIMULATING FACTORS [CLOSED CLASS]		
FULPHILA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-jmdb*)	Preferred	
NEUPOGEN INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*filgrastim*)	Preferred	
NEUPOGEN INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim*)	Preferred	
releuko injection solution 480 mcg/1.6ml	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
releuko subcutaneous solution prefilled syringe 300 mcg/0.5ml, 480 mcg/0.8ml	Non Preferred	PA
FYLNETRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-pbbk*)	Non Preferred	PA
GRANIX SUBCUTANEOUS SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*tbo-filgrastim*)	Non Preferred	PA
GRANIX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*tbo-filgrastim*)	Non Preferred	PA
LEUKINE INJECTION SOLUTION RECONSTITUTED 250 MCG (*sargramostim*)	Non Preferred	PA
NEULASTA ONPRO SUBCUTANEOUS PREFILLED SYRINGE KIT 6 MG/0.6ML (*pegfilgrastim*)	Non Preferred	PA
NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim*)	Non Preferred	PA
NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6ML (*filgrastim-aafi*)	Non Preferred	PA
NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-aafi*)	Non Preferred	PA
NYVEPRIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-apgf*)	Non Preferred	PA
RELEUKO INJECTION SOLUTION 300 MCG/ML (*filgrastim-ayow*)	Non Preferred	PA
ROLVEDON SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 13.2 MG/0.6ML (*eflapegrastim-xnst*)	Non Preferred	PA
STIMUFEND SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-fpgk*)	Non Preferred	PA
UDENYCA ONBODY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-cbqv*)	Non Preferred	PA
UDENYCA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6 MG/0.6ML (*pegfilgrastim-cbqv*)	Non Preferred	PA
UDENYCA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-cbqv*)	Non Preferred	PA
ZARXIO INJECTION SOLUTION PREFILLED SYRINGE 300 MCG/0.5ML, 480 MCG/0.8ML (*filgrastim-sndz*)	Non Preferred	PA
ZIEXTENZO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6 MG/0.6ML (*pegfilgrastim-bmez*)	Non Preferred	PA
CONTRACEPTIVES: LONG-ACTING IUDS & INJECTABLES [OPEN CLASS]		
medroxyprogesterone acetate intramuscular suspension 150 mg/ml	Preferred	Max 365-day supply per 1 Fill
medroxyprogesterone acetate intramuscular suspension prefilled syringe 150 mg/ml	Preferred	Max 365-day supply per 1 Fill
DEPO-SUBQ PROVERA 104 SUBCUTANEOUS SUSPENSION PREFILLED SYRINGE 104 MG/0.65ML (*medroxyprogesterone acetate*)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
KYLEENA INTRAUTERINE INTRAUTERINE DEVICE 19.5 MG (*levonorgestrel*)	Preferred	Max 365-day supply per 1 Fill
LILETTA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20.1 MCG/DAY (*levonorgestrel*)	Preferred	Max 365-day supply per 1 Fill
MIRENA (52 MG) INTRAUTERINE INTRAUTERINE DEVICE 20 MCG/DAY (*levonorgestrel*)	Preferred	Max 365-day supply per 1 Fill
NEXPLANON SUBCUTANEOUS IMPLANT 68 MG (*etonogestrel*)	Preferred	Max 365-day supply per 1 Fill
PARAGARD INTRAUTERINE COPPER INTRAUTERINE INTRAUTERINE DEVICE (*copper*)	Preferred	Max 365-day supply per 1 Fill
SKYLA INTRAUTERINE INTRAUTERINE DEVICE 13.5 MG (*levonorgestrel*)	Preferred	Max 365-day supply per 1 Fill
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML (*medroxyprogesterone acetate*)	Non Preferred	PA; Max 365-day supply per 1 Fill
DEPO-PROVERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 150 MG/ML (*medroxyprogesterone acetate*)	Non Preferred	PA; Max 365-day supply per 1 Fill
COPD: BRONCHODILATORS AND PHOSPHODIESTERASE 4 (PDE4) INHIBITORS [CLOSED CLASS]		
ipratropium bromide inhalation solution 0.02 %	Preferred	90-day fill allowed after two 1-month fills
ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg/3ml	Preferred	90-day fill allowed after two 1-month fills
roflumilast oral tablet 250 mcg, 500 mcg	Preferred	PA; AGE (Min 18 Years)
ANORO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5-25 MCG/ACT (*umeclidinium-vilanterol*)	Preferred	90-day fill allowed after two 1-month fills
ATROVENT HFA INHALATION AEROSOL SOLUTION 17 MCG/ACT (*ipratropium bromide hfa*)	Preferred	90-day fill allowed after two 1-month fills
COMBIVENT RESPIMAT INHALATION AEROSOL SOLUTION 20-100 MCG/ACT (*ipratropium-albuterol*)	Preferred	90-day fill allowed after two 1-month fills
SPIRIVA HANDIHALER INHALATION CAPSULE 18 MCG (*tiotropium bromide monohydrate*)	Preferred	90-day fill allowed after two 1-month fills
SPIRIVA RESPIMAT INHALATION AEROSOL SOLUTION 1.25 MCG/ACT, 2.5 MCG/ACT (*tiotropium bromide monohydrate*)	Preferred	90-day fill allowed after two 1-month fills
STIOLTO RESPIMAT INHALATION AEROSOL SOLUTION 2.5-2.5 MCG/ACT (*tiotropium bromide-olodaterol*)	Preferred	90-day fill allowed after two 1-month fills
tiotropium bromide monohydrate inhalation capsule 18 mcg	Non Preferred	PA
BEVESPI AEROSPHERE INHALATION AEROSOL 9-4.8 MCG/ACT (*glycopyrrolate-formoterol*)	Non Preferred	PA
DALIRESP ORAL TABLET 250 MCG, 500 MCG (*roflumilast*)	Non Preferred	PA; AGE (Min 18 Years)
DUAKLIR PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400-12 MCG/ACT (*aclidinium br-formoterol fum*)	Non Preferred	PA; AGE (Min 18 Years)
INCRUSE ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 62.5 MCG/ACT (*umeclidinium bromide*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
TUDORZA PRESSAIR INHALATION AEROSOL POWDER BREATH ACTIVATED 400 MCG/ACT (*aclidinium bromide*)	Non Preferred	PA
YUPELRI INHALATION SOLUTION 175 MCG/3ML (*revefenacin*)	Non Preferred	PA
COUGH AND COLD [OPEN CLASS]		
guaifenesin-codeine oral solution 100-10 mg/5ml, 200-20 mg/10ml	Preferred	AGE (Min 18 Years)
hydrocodone bit-homatrop mbr oral solution 5-1.5 mg/5ml	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
hydromet oral solution 5-1.5 mg/5ml	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
promethazine-codeine oral solution 6.25-10 mg/5ml	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
promethazine-codeine oral syrup 6.25-10 mg/5ml	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
HYCODAN ORAL SOLUTION 5-1.5 MG/5ML (*hydrocodone bit-homatrop mbr*)	Preferred	QL (30 ML per 1 day); AGE (Min 18 Years)
hydrocod poli-chlorphe poli er oral suspension extended release 10-8 mg/5ml	Non Preferred	PA; AGE (Min 6 Years)
hydrocodone bit-homatrop mbr oral tablet 5-1.5 mg	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
poly-tussin ac oral liquid 10-4-10 mg/5ml	Non Preferred	PA; AGE (Min 6 Years)
promethazine vc/codeine oral syrup 6.25-5-10 mg/5ml	Non Preferred	PA; AGE (Min 18 Years)
HISTEX-AC ORAL SYRUP 10-2.5-10 MG/5ML (*phenyleph-triprolidine-codeine*)	Non Preferred	PA; AGE (Min 6 Years)
HYCODAN ORAL TABLET 5-1.5 MG (*hydrocodone bit-homatrop mbr*)	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
MAR-COF CG EXPECTORANT ORAL LIQUID 225-7.5 MG/5ML (*guaifenesin-codeine*)	Non Preferred	PA; AGE (Min 18 Years)
NINJACOF-XG ORAL LIQUID 200-8 MG/5ML (*guaifenesin-codeine*)	Non Preferred	PA; AGE (Min 18 Years)
TUXARIN ER ORAL TABLET EXTENDED RELEASE 12 HOUR 54.3-8 MG (*chlorpheniramine-codeine*)	Non Preferred	PA; AGE (Min 6 Years)
CYTOKINE AND CAM ANTAGONISTS AND RELATED AGENTS [CLOSED CLASS]		
infliximab intravenous solution reconstituted 100 mg	Preferred	SP
methotrexate sodium (pf) injection solution 1 gm/40ml, 250 mg/10ml, 50 mg/2ml	Preferred	90-day fill allowed after two 1-month fills
methotrexate sodium injection solution 1000 mg/40ml, 250 mg/10ml, 50 mg/2ml	Preferred	90-day fill allowed after two 1-month fills
methotrexate sodium injection solution reconstituted 1 gm	Preferred	
methotrexate sodium oral tablet 2.5 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
ENBREL MINI SUBCUTANEOUS SOLUTION CARTRIDGE 50 MG/ML (*etanercept*)	Preferred	SP; QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML (*etanercept*)	Preferred	SP; QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML (*etanercept*)	Preferred	SP; QL (4 ML per 34 days); AGE (Min 2 Years)
ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50 MG/ML (*etanercept*)	Preferred	SP; QL (8 ML per 34 days); AGE (Min 2 Years)
ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 50 MG/ML (*etanercept*)	Preferred	SP; QL (8 ML per 34 days); AGE (Min 2 Years)
HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PED<40KG CROHNS STARTER SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML & 40MG/0.4ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PED>/=40KG CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PED>/=40KG UC STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS PEN-INJECTOR KIT 80 MG/0.8ML & 40MG/0.4ML (*adalimumab*)	Preferred	SP; AGE (Min 2 Years)
adalimumab-aacf (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-aacf (2 syringe) subcutaneous prefilled syringe kit 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-aacf(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-aacf(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-aaty (1 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 80 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-aaty (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-aaty (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.2ml, 40 mg/0.4ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-adaz subcutaneous solution auto-injector 40 mg/0.4ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-adaz subcutaneous solution prefilled syringe 40 mg/0.4ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-adbm (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)

Drug Name	Formulary Status	Requirements/Limits
adalimumab-adbm (2 syringe) subcutaneous prefilled syringe kit 10 mg/0.2ml, 20 mg/0.4ml, 40 mg/0.4ml, 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-adbm(cd/uc/hs strt) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-adbm(ps/uv starter) subcutaneous auto-injector kit 40 mg/0.4ml, 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-fkjp (2 pen) subcutaneous auto-injector kit 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-fkjp (2 syringe) subcutaneous prefilled syringe kit 20 mg/0.4ml, 40 mg/0.8ml	Non Preferred	SP; PA; AGE (Min 2 Years)
adalimumab-ryvk (2 pen) subcutaneous auto-injector kit 40 mg/0.4ml	Non Preferred	SP; PA; AGE (Min 2 Years)
ABRILADA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-afzb*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ABRILADA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-afzb*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ABRILADA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (*adalimumab-afzb*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ACTEMRA ACTPEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab*)	Non Preferred	SP; PA
ACTEMRA INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (*tocilizumab*)	Non Preferred	SP; PA
ACTEMRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab*)	Non Preferred	SP; PA
AMJEVITA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML (*adalimumab-atto*)	Non Preferred	SP; PA; AGE (Min 2 Years)
AMJEVITA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-atto*)	Non Preferred	SP; PA; AGE (Min 2 Years)
AMJEVITA-PED 10KG TO <15KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.2ML (*adalimumab-atto*)	Non Preferred	SP; PA; AGE (Min 2 Years)
AMJEVITA-PED 15KG TO <30KG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.2ML, 20 MG/0.4ML (*adalimumab-atto*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ARCALYST SUBCUTANEOUS SOLUTION RECONSTITUTED 220 MG (*rilonacept*)	Non Preferred	SP; PA
AVSOLA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-axxq*)	Non Preferred	SP; PA
BIMZELX SUBCUTANEOUS SOLUTION AUTO-INJECTOR 160 MG/ML (*bimekizumab-bkzx*)	Non Preferred	SP; PA; AGE (Min 18 Years)
BIMZELX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 160 MG/ML (*bimekizumab-bkzx*)	Non Preferred	SP; PA; AGE (Min 18 Years)
CIBINQO ORAL TABLET 100 MG, 200 MG, 50 MG (*abrocitinib*)	Non Preferred	PA; AGE (Min 18 Years)
CIMZIA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 200 MG/ML (*certolizumab pegol*)	Non Preferred	SP; PA

Drug Name	Formulary Status	Requirements/Limits
CIMZIA STARTER KIT SUBCUTANEOUS PREFILLED SYRINGE KIT 6 X 200 MG/ML (*certolizumab pegol*)	Non Preferred	SP; PA
CIMZIA SUBCUTANEOUS KIT 2 X 200 MG (*certolizumab pegol*)	Non Preferred	SP; PA
COSENTYX (300 MG DOSE) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*secukinumab*)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX INTRAVENOUS SOLUTION 125 MG/5ML (*secukinumab*)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX SENSOREADY (300 MG) SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*secukinumab*)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML (*secukinumab*)	Non Preferred	SP; PA; AGE (Min 2 Years)
COSENTYX UNOREADY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 300 MG/2ML (*secukinumab*)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.2ML, 20 MG/0.4ML, 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	Non Preferred	SP; PA; AGE (Min 2 Years)
CYLTEZO-PSORIASIS/UV STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-adbm*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ENSPRYNG SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 120 MG/ML (*satralizumab-mwge*)	Non Preferred	SP; PA
ENTYVIO INTRAVENOUS SOLUTION RECONSTITUTED 300 MG (*vedolizumab*)	Non Preferred	SP; PA
ENTYVIO SUBCUTANEOUS SOLUTION PEN-INJECTOR 108 MG/0.68ML (*vedolizumab*)	Non Preferred	SP; PA
HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-bwwd*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML (*adalimumab-bwwd*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HULIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-fkjp*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HULIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.4ML, 40 MG/0.8ML (*adalimumab-fkjp*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 80 MG/0.8ML (*adalimumab-adaz*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.1 ML, 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab-adaz*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ-CROHNS/UC STARTER SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML (*adalimumab-adaz*)	Non Preferred	SP; PA; AGE (Min 2 Years)

Drug Name	Formulary Status	Requirements/Limits
HYRIMOZ-PED<40KG CROHN STARTER SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ-PED>/=40KG CROHN START SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/0.8ML (*adalimumab-adaz*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HYRIMOZ-PLAQ PSOR/UVEIT START SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML & 40MG/0.4ML (*adalimumab-adaz*)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML (*adalimumab-aacf*)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO-CROHNS/UC STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	Non Preferred	SP; PA; AGE (Min 2 Years)
IDACIO-PSORIASIS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.8ML (*adalimumab-aacf*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ILARIS SUBCUTANEOUS SOLUTION 150 MG/ML (*canakinumab*)	Non Preferred	SP; PA
ILUMYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*tildrakizumab-asmn*)	Non Preferred	SP; PA; AGE (Min 18 Years)
INFLECTRA INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-dyyb*)	Non Preferred	SP; PA
JYLAMVO ORAL SOLUTION 2 MG/ML (*methotrexate*)	Non Preferred	PA
KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	Non Preferred	SP; PA; AGE (Min 18 Years)
KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/1.14ML, 200 MG/1.14ML (*sarilumab*)	Non Preferred	SP; PA; AGE (Min 18 Years)
KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*anakinra*)	Non Preferred	SP; PA
LITFULO ORAL CAPSULE 50 MG (*ritlecitinib tosylate*)	Non Preferred	PA; AGE (Min 12 Years)
OLUMIANT ORAL TABLET 1 MG, 2 MG, 4 MG (*baricitinib*)	Non Preferred	SP; PA; AGE (Min 18 Years)
OMVOH INTRAVENOUS SOLUTION 300 MG/15ML (*mirikizumab-mrkz*)	Non Preferred	SP; PA; QL (45 ML per 84 days); AGE (Min 18 Years)
OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mirikizumab-mrkz*)	Non Preferred	SP; PA; QL (2 ML per 28 days); AGE (Min 18 Years)
OMVOH SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mirikizumab-mrkz*)	Non Preferred	SP; PA; QL (2 ML per 28 days); AGE (Min 18 Years)
ORENCIA CLICKJECT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 125 MG/ML (*abatacept*)	Non Preferred	SP; PA
ORENCIA INTRAVENOUS SOLUTION RECONSTITUTED 250 MG (*abatacept*)	Non Preferred	SP; PA
ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML (*abatacept*)	Non Preferred	SP; PA

Drug Name	Formulary Status	Requirements/Limits
OTEZLA ORAL TABLET 20 MG (*apremilast*)	Non Preferred	PA
OTEZLA ORAL TABLET 30 MG (*apremilast*)	Non Preferred	SP; PA
OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG (*apremilast*)	Non Preferred	SP; PA
OTEZLA ORAL TABLET THERAPY PACK 4 X 10 & 51 X20 MG (*apremilast*)	Non Preferred	PA
OTREXUP SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.4ML, 12.5 MG/0.4ML, 15 MG/0.4ML, 17.5 MG/0.4ML, 20 MG/0.4ML, 22.5 MG/0.4ML, 25 MG/0.4ML (*methotrexate (anti-rheumatic)*)	Non Preferred	PA
RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML (*methotrexate (anti-rheumatic)*)	Non Preferred	PA
REMICADE INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab*)	Non Preferred	SP; PA
RENFLEXIS INTRAVENOUS SOLUTION RECONSTITUTED 100 MG (*infliximab-abda*)	Non Preferred	SP; PA
RINVOQ LQ ORAL SOLUTION 1 MG/ML (*upadacitinib*)	Non Preferred	SP; PA
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG (*upadacitinib*)	Non Preferred	SP; PA
SILIQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.5ML (*brodalumab*)	Non Preferred	SP; PA; AGE (Min 18 Years)
SIMLANDI (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-ryvk*)	Non Preferred	SP; PA; AGE (Min 2 Years)
SIMLANDI (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-ryvk*)	Non Preferred	SP; PA; AGE (Min 2 Years)
SIMPONI ARIA INTRAVENOUS SOLUTION 50 MG/4ML (*golimumab*)	Non Preferred	SP; PA
SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 50 MG/0.5ML (*golimumab*)	Non Preferred	SP; PA
SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 50 MG/0.5ML (*golimumab*)	Non Preferred	SP; PA
SKYRIZI INTRAVENOUS SOLUTION 600 MG/10ML (*risankizumab-rzaa*)	Non Preferred	SP; PA
SKYRIZI PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML (*risankizumab-rzaa*)	Non Preferred	SP; PA
SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML (*risankizumab-rzaa*)	Non Preferred	SP; PA
SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*risankizumab-rzaa*)	Non Preferred	SP; PA
SOTYKTU ORAL TABLET 6 MG (*deucravacitinib*)	Non Preferred	SP; PA

Drug Name	Formulary Status	Requirements/Limits
SPEVIGO INTRAVENOUS SOLUTION 450 MG/7.5ML (*spesolimab-sbzo*)	Non Preferred	SP; PA; AGE (Min 12 Years)
SPEVIGO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*spesolimab-sbzo*)	Non Preferred	SP; PA; AGE (Min 18 Years)
STELARA INTRAVENOUS SOLUTION 130 MG/26ML (*ustekinumab*)	Non Preferred	SP; PA
STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML (*ustekinumab*)	Non Preferred	SP; PA
STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML (*ustekinumab*)	Non Preferred	SP; PA
TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/ML (*ixekizumab*)	Non Preferred	SP; PA
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML (*ixekizumab*)	Non Preferred	PA
TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 80 MG/ML (*ixekizumab*)	Non Preferred	SP; PA
TOFIDENCE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (*tocilizumab-bavi*)	Non Preferred	SP; PA; AGE (Min 2 Years)
TREMFYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 MG/ML (*guselkumab*)	Non Preferred	SP; PA
TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML (*guselkumab*)	Non Preferred	SP; PA
TREXALL ORAL TABLET 10 MG, 15 MG, 5 MG, 7.5 MG (*methotrexate sodium*)	Non Preferred	PA
TYENNE INTRAVENOUS SOLUTION 200 MG/10ML, 400 MG/20ML, 80 MG/4ML (*tocilizumab-aazg*)	Non Preferred	SP; PA; AGE (Min 2 Years)
TYENNE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 162 MG/0.9ML (*tocilizumab-aazg*)	Non Preferred	SP; PA; AGE (Min 2 Years)
TYENNE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 162 MG/0.9ML (*tocilizumab-aazg*)	Non Preferred	SP; PA; AGE (Min 2 Years)
UPLIZNA INTRAVENOUS SOLUTION 100 MG/10ML (*inebilizumab-cdon*)	Non Preferred	SP; PA; AGE (Min 18 Years)
VELSIPITY ORAL TABLET 2 MG (*etrasimod arginine*)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 18 Years)
XATMEP ORAL SOLUTION 2.5 MG/ML (*methotrexate*)	Non Preferred	PA
XELJANZ ORAL SOLUTION 1 MG/ML (*tofacitinib citrate*)	Non Preferred	SP; PA
XELJANZ ORAL TABLET 10 MG, 5 MG (*tofacitinib citrate*)	Non Preferred	SP; PA
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG (*tofacitinib citrate*)	Non Preferred	SP; PA
YUFLYMA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML, 80 MG/0.8ML (*adalimumab-aaty*)	Non Preferred	SP; PA; AGE (Min 2 Years)
YUFLYMA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML (*adalimumab-aaty*)	Non Preferred	SP; PA; AGE (Min 2 Years)

Drug Name	Formulary Status	Requirements/Limits
YUFLYMA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 20 MG/0.2ML, 40 MG/0.4ML (*adalimumab-aaty*)	Non Preferred	SP; PA; AGE (Min 2 Years)
YUFLYMA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML (*adalimumab-aaty*)	Non Preferred	SP; PA; AGE (Min 2 Years)
YUSIMRY SUBCUTANEOUS SOLUTION PEN-INJECTOR 40 MG/0.8ML (*adalimumab-aqvh*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ZYMFENTRA (1 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (*infliximab-dyyb*)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZYMFENTRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 120 MG/ML (*infliximab-dyyb*)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZYMFENTRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 120 MG/ML (*infliximab-dyyb*)	Non Preferred	SP; PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: ALPHA-GLUCOSIDASE INHIBITORS [OPEN CLASS]		
acarbose oral tablet 100 mg, 25 mg, 50 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
miglitol oral tablet 100 mg, 25 mg, 50 mg	Non Preferred	PA; AGE (Min 18 Years)
PRECOSE ORAL TABLET 100 MG, 25 MG, 50 MG (*acarbose*)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: BIGUANIDES (METFORMIN) [OPEN CLASS]		
glipizide-metformin hcl oral tablet 2.5-250 mg, 2.5-500 mg, 5-500 mg	Preferred	AGE (Min 18 Years)
glyburide-metformin oral tablet 1.25-250 mg, 5-500 mg	Preferred	AGE (Min 18 Years)
glyburide-metformin oral tablet 2.5-500 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
metformin hcl er oral tablet extended release 24 hour 500 mg, 750 mg	Preferred	AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
metformin hcl oral tablet 1000 mg, 500 mg, 850 mg	Preferred	AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
metformin hcl er (mod) oral tablet extended release 24 hour 1000 mg, 500 mg	Non Preferred	PA; AGE (Min 10 Years)
metformin hcl er (osm) oral tablet extended release 24 hour 1000 mg, 500 mg	Non Preferred	PA; AGE (Min 10 Years)
metformin hcl oral solution 500 mg/5ml	Non Preferred	PA; AGE (Min 10 Years)
metformin hcl oral tablet 625 mg	Non Preferred	PA; AGE (Min 10 Years)
GLUMETZA ORAL TABLET EXTENDED RELEASE 24 HOUR 1000 MG, 500 MG (*metformin hcl*)	Non Preferred	PA; AGE (Min 10 Years)
RIOMET ER ORAL SUSPENSION RECONSTITUTED ER 500 MG/5ML (*metformin hcl*)	Non Preferred	PA; AGE (Min 10 Years)

Drug Name	Formulary Status	Requirements/Limits
RIOMET ORAL SOLUTION 500 MG/5ML (*metformin hcl*)	Non Preferred	PA; AGE (Min 10 Years)
DIABETES ORAL HYPOGLYCEMICS: DPP-IV INHIBITORS AND COMBINATIONS [CLOSED CLASS]		
JANUMET ORAL TABLET 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JANUMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 100-1000 MG, 50-1000 MG, 50-500 MG (*sitagliptin-metformin hcl*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JANUVIA ORAL TABLET 100 MG, 25 MG, 50 MG (*sitagliptin phosphate*)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JENTADUETO ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 2.5-850 MG (*linagliptin-metformin hcl*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JENTADUETO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG (*linagliptin-metformin hcl*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
KOMBIGLYZE XR ORAL TABLET EXTENDED RELEASE 24 HOUR 2.5-1000 MG, 5-1000 MG, 5-500 MG (*saxagliptin-metformin*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
ONGLYZA ORAL TABLET 2.5 MG, 5 MG (*saxagliptin hcl*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
TRADJENTA ORAL TABLET 5 MG (*linagliptin*)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
alogliptin benzoate oral tablet 12.5 mg, 25 mg, 6.25 mg	Non Preferred	PA; AGE (Min 18 Years)
alogliptin-metformin hcl oral tablet 12.5-1000 mg, 12.5-500 mg	Non Preferred	PA; AGE (Min 18 Years)
alogliptin-pioglitazone oral tablet 12.5-30 mg, 25-15 mg, 25-30 mg, 25-45 mg	Non Preferred	PA; AGE (Min 18 Years)
saxagliptin hcl oral tablet 2.5 mg, 5 mg	Non Preferred	PA; AGE (Min 18 Years)
saxagliptin-metformin er oral tablet extended release 24 hour 2.5-1000 mg, 5-1000 mg, 5-500 mg	Non Preferred	PA; AGE (Min 18 Years)
sitagliptin oral tablet 100 mg, 25 mg, 50 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
GLYXAMBI ORAL TABLET 10-5 MG, 25-5 MG (*empagliflozin-linagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
KAZANO ORAL TABLET 12.5-1000 MG, 12.5-500 MG (*alogliptin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
NESINA ORAL TABLET 12.5 MG, 25 MG, 6.25 MG (*alogliptin benzoate*)	Non Preferred	PA; AGE (Min 18 Years)
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG (*alogliptin-pioglitazone*)	Non Preferred	PA; AGE (Min 18 Years)
QTERN ORAL TABLET 10-5 MG, 5-5 MG (*dapagliflozin-saxagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
STEGLUJAN ORAL TABLET 15-100 MG, 5-100 MG (*ertugliflozin-sitagliptin*)	Non Preferred	PA; AGE (Min 18 Years)
TRIJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-5-1000 MG, 12.5-2.5-1000 MG, 25-5-1000 MG, 5-2.5-1000 MG (*empagliflozin-linaglip-metform*)	Non Preferred	PA; AGE (Min 18 Years)
ZITUVIO ORAL TABLET 100 MG, 25 MG, 50 MG (*sitagliptin*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: MEGLINITIDES [OPEN CLASS]		
nateglinide oral tablet 120 mg, 60 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
repaglinide oral tablet 0.5 mg, 1 mg, 2 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
DIABETES ORAL HYPOGLYCEMICS: SECOND GENERATION SULFONYLUREAS [OPEN CLASS]		
glimepiride oral tablet 1 mg, 2 mg, 4 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
glimepiride oral tablet 3 mg	Preferred	AGE (Min 18 Years)
glipizide er oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
glipizide oral tablet 10 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
glipizide oral tablet 2.5 mg	Preferred	QL (16 EA per 1 day); AGE (Min 18 Years)
glipizide xl oral tablet extended release 24 hour 10 mg, 2.5 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
glyburide micronized oral tablet 1.5 mg, 3 mg, 6 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
glyburide oral tablet 1.25 mg, 2.5 mg, 5 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 10 MG, 2.5 MG, 5 MG (*glipizide*)	Non Preferred	PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
GLYNASE ORAL TABLET 1.5 MG, 3 MG, 6 MG (*glyburide micronized*)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: SODIUM GLUCOSE CO-TRANSPORTER 2 INHIBITOR [CLOSED CLASS]		
FARXIGA ORAL TABLET 10 MG, 5 MG (*dapagliflozin propanediol*)	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
JARDIANCE ORAL TABLET 10 MG, 25 MG (*empagliflozin*)	Preferred	QL (1 EA per 1 day); AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
SYNJARDY ORAL TABLET 12.5-1000 MG, 12.5-500 MG, 5-1000 MG, 5-500 MG (*empagliflozin-metformin hcl*)	Preferred	AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
SYNJARDY XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 12.5-1000 MG, 25-1000 MG, 5-1000 MG (*empagliflozin-metformin hcl*)	Preferred	AGE (Min 18 Years)
XIGDUO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 10-1000 MG, 10-500 MG, 2.5-1000 MG, 5-1000 MG, 5-500 MG (*dapagliflozin prop-metformin*)	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
dapagliflozin pro-metformin er oral tablet extended release 24 hour 10-1000 mg, 5-1000 mg	Non Preferred	PA; AGE (Min 18 Years)
dapagliflozin propanediol oral tablet 10 mg, 5 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
sitagliptin base-metformin hcl oral tablet 50-1000 mg, 50-500 mg	Non Preferred	PA; AGE (Min 18 Years)
INPEFA ORAL TABLET 200 MG, 400 MG (*sotagliflozin*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
INVOKAMET ORAL TABLET 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (*canagliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years)
INVOKAMET XR ORAL TABLET EXTENDED RELEASE 24 HOUR 150-1000 MG, 150-500 MG, 50-1000 MG, 50-500 MG (*canagliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years)
INVOKANA ORAL TABLET 100 MG (*canagliflozin*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
INVOKANA ORAL TABLET 300 MG (*canagliflozin*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SEGLUROMET ORAL TABLET 2.5-1000 MG, 2.5-500 MG, 7.5-1000 MG, 7.5-500 MG (*ertugliflozin-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years)
STEGLATRO ORAL TABLET 15 MG, 5 MG (*ertugliflozin l-pyroglutamicac*)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES ORAL HYPOGLYCEMICS: THIAZOLIDINEDIONES [OPEN CLASS]		
pioglitazone hcl oral tablet 15 mg, 30 mg, 45 mg	Preferred	AGE (Min 18 Years); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
pioglitazone hcl-glimepiride oral tablet 30-2 mg, 30-4 mg	Non Preferred	PA; AGE (Min 18 Years)
pioglitazone hcl-metformin hcl oral tablet 15-500 mg, 15-850 mg	Non Preferred	PA; AGE (Min 18 Years)
ACTOPLUS MET ORAL TABLET 15-850 MG (*pioglitazone hcl-metformin hcl*)	Non Preferred	PA; AGE (Min 18 Years)
ACTOS ORAL TABLET 15 MG, 30 MG, 45 MG (*pioglitazone hcl*)	Non Preferred	PA; AGE (Min 18 Years)
DUETACT ORAL TABLET 30-2 MG, 30-4 MG (*pioglitazone hcl-glimepiride*)	Non Preferred	PA; AGE (Min 18 Years)
DIABETES: INJECTABLE AMYLIN ANALOGS [CLOSED CLASS]		
SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR 2700 MCG/2.7ML (*pramlintide acetate*)	Non Preferred	PA
SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR 1500 MCG/1.5ML (*pramlintide acetate*)	Non Preferred	PA
DIABETES: INJECTABLE AND ORAL INCRETIN MIMETICS [CLOSED CLASS]		
BYETTA 10 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MCG/0.04ML (*exenatide*)	Preferred	PA (Eligible for auto-PA approval); QL (7.2 ML per 90 days); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
BYETTA 5 MCG PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MCG/0.02ML (*exenatide*)	Preferred	PA (Eligible for auto-PA approval); QL (3.6 ML per 90 days); AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
TRULICITY SUBCUTANEOUS SOLUTION PEN-INJECTOR 0.75 MG/0.5ML, 1.5 MG/0.5ML, 3 MG/0.5ML, 4.5 MG/0.5ML (*dulaglutide*)	Preferred	PA (Eligible for auto-PA approval); QL (6 ML per 84 days); AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide*)	Preferred	PA (Eligible for auto-PA approval); QL (27 ML per 90 days); AGE (Min 10 Years); 90-day fill allowed after two 1-month fills
BYDUREON BCISE SUBCUTANEOUS AUTO-INJECTOR 2 MG/0.85ML (*exenatide*)	Non Preferred	PA; QL (3.4 ML per 28 days); AGE (Min 10 Years)
MOUNJARO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide*)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML (*semaglutide*)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML (*semaglutide*)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
OZEMPIC (2 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 8 MG/3ML (*semaglutide*)	Non Preferred	PA; QL (3 ML per 28 days); AGE (Min 18 Years)
RYBELSUS ORAL TABLET 14 MG, 3 MG, 7 MG (*semaglutide*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SOLIQUA SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-33 UNT-MCG/ML (*insulin glargine-lixisenatide*)	Non Preferred	PA; AGE (Min 18 Years)
XULTOPHY SUBCUTANEOUS SOLUTION PEN-INJECTOR 100-3.6 UNIT-MG/ML (*insulin degludec-liraglutide*)	Non Preferred	PA; QL (15 ML per 28 days); AGE (Min 18 Years)
DUCHENNE MUSCULAR DYSTROPHY [CLOSED CLASS]		
amondys 45 intravenous solution 100 mg/2ml	Non Preferred	PA
AGAMREE ORAL SUSPENSION 40 MG/ML (*vamorolone*)	Non Preferred	PA; AGE (Min 2 Years)
DUVYZAT ORAL SUSPENSION 8.86 MG/ML (*givinostat hcl*)	Non Preferred	PA; AGE (Min 6 Years)
EXONDYS 51 INTRAVENOUS SOLUTION 100 MG/2ML, 500 MG/10ML (*eteplirsen*)	Non Preferred	SP; PA
VILTEPSO INTRAVENOUS SOLUTION 250 MG/5ML (*viltolarsen*)	Non Preferred	SP; PA
VYONDYS 53 INTRAVENOUS SOLUTION 100 MG/2ML (*golodirsen*)	Non Preferred	SP; PA
EPINEPHRINE: SELF-INJECTED [OPEN CLASS]		
epinephrine injection solution auto-injector 0.15 mg/0.3ml, 0.3 mg/0.3ml	Preferred	QL (12 EA per 365 days)
EPIPEN 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.3 MG/0.3ML (*epinephrine*)	Preferred	QL (12 EA per 365 days)
EPIPEN JR 2-PAK INJECTION SOLUTION AUTO-INJECTOR 0.15 MG/0.3ML (*epinephrine*)	Preferred	QL (12 EA per 365 days)
epinephrine injection solution auto-injector 0.15 mg/0.15ml	Non Preferred	PA; QL (12 EA per 365 days)
AUVI-Q INJECTION SOLUTION AUTO-INJECTOR 0.1 MG/0.1ML, 0.15 MG/0.15ML, 0.3 MG/0.3ML (*epinephrine*)	Non Preferred	PA; QL (12 EA per 365 days)
SYMJEPI INJECTION SOLUTION PREFILLED SYRINGE 0.15 MG/0.3ML, 0.3 MG/0.3ML (*epinephrine*)	Non Preferred	PA; QL (12 EA per 365 days)
ERYTHROPOIESIS STIMULATING PROTEINS [OPEN CLASS]		
EPOGEN INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML (*epoetin alfa*)	Preferred	
RETACRIT INJECTION SOLUTION 40000 UNIT/ML (*epoetin alfa-epbx*)	Preferred	
RETACRIT SOLUTION 10000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Preferred	
RETACRIT SOLUTION 2000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
RETACRIT SOLUTION 20000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Preferred	
RETACRIT SOLUTION 3000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Preferred	
RETACRIT SOLUTION 4000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Preferred	
ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML (*darbepoetin alfa*)	Non Preferred	PA
ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE 10 MCG/0.4ML, 100 MCG/0.5ML, 150 MCG/0.3ML, 200 MCG/0.4ML, 25 MCG/0.42ML, 300 MCG/0.6ML, 40 MCG/0.4ML, 500 MCG/ML, 60 MCG/0.3ML (*darbepoetin alfa*)	Non Preferred	PA
JESDUVROQ ORAL TABLET 1 MG, 2 MG, 4 MG, 6 MG, 8 MG (*daprodustat*)	Non Preferred	PA; AGE (Min 18 Years)
MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 120 MCG/0.3ML, 150 MCG/0.3ML, 200 MCG/0.3ML, 30 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML (*methoxy peg-epoetin beta*)	Non Preferred	PA
PROCRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML (*epoetin alfa*)	Non Preferred	PA
RETACRIT SOLUTION 10000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Non Preferred	PA
RETACRIT SOLUTION 2000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Non Preferred	PA
RETACRIT SOLUTION 20000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Non Preferred	PA
RETACRIT SOLUTION 3000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Non Preferred	PA
RETACRIT SOLUTION 4000 UNIT/ML INJECTION (*epoetin alfa-epbx*)	Non Preferred	PA
GI ANTIBIOTICS [OPEN CLASS]		
metronidazole oral tablet 250 mg, 500 mg	Preferred	
neomycin sulfate oral tablet 500 mg	Preferred	
vancomycin hcl oral capsule 125 mg, 250 mg	Preferred	
FIRVANQ ORAL SOLUTION RECONSTITUTED 25 MG/ML, 50 MG/ML (*vancomycin hcl*)	Preferred	
metronidazole oral capsule 375 mg	Non Preferred	PA
nitazoxanide oral tablet 500 mg	Non Preferred	PA
paromomycin sulfate oral capsule 250 mg	Non Preferred	PA
tinidazole oral tablet 250 mg, 500 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
vancomycin hcl oral solution reconstituted 25 mg/ml, 250 mg/5ml, 50 mg/ml	Non Preferred	PA
AEMCOLO ORAL TABLET DELAYED RELEASE 194 MG (*rifamycin sodium*)	Non Preferred	PA
DIFICID ORAL SUSPENSION RECONSTITUTED 40 MG/ML (*fidaxomicin*)	Non Preferred	PA; AGE (Max 16 Years)
DIFICID ORAL TABLET 200 MG (*fidaxomicin*)	Non Preferred	PA
FLAGYL ORAL CAPSULE 375 MG (*metronidazole*)	Non Preferred	PA
LIKMEZ ORAL SUSPENSION 500 MG/5ML (*metronidazole*)	Non Preferred	PA
SOLOSEC ORAL PACKET 2 GM (*secnidazole*)	Non Preferred	PA
VANCOCIN ORAL CAPSULE 125 MG, 250 MG (*vancomycin hcl*)	Non Preferred	PA
VOWST ORAL CAPSULE (*fecal microb spores, live-brpk*)	Non Preferred	SP; PA; AGE (Min 18 Years)
XIFAXAN ORAL TABLET 200 MG (*rifaximin*)	Non Preferred	PA; AGE (Min 12 Years)
XIFAXAN ORAL TABLET 550 MG (*rifaximin*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 18 Years)
GI MOTILITY: CHRONIC [OPEN CLASS]		
lubiprostone oral capsule 24 mcg, 8 mcg	Preferred	PA; AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
LINZESS ORAL CAPSULE 145 MCG, 290 MCG (*linaclotide*)	Preferred	PA; AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
LINZESS ORAL CAPSULE 72 MCG (*linaclotide*)	Preferred	PA; AGE (Min 6 Years); 90-day fill allowed after two 1-month fills
MOVANTIK ORAL TABLET 12.5 MG, 25 MG (*naloxegol oxalate*)	Preferred	PA; AGE (Min 18 Years); 90-day fill allowed after two 1-month fills
alosetron hcl oral tablet 0.5 mg, 1 mg	Non Preferred	PA; AGE (Min 18 Years)
AMITIZA ORAL CAPSULE 24 MCG, 8 MCG (*lubiprostone*)	Non Preferred	PA; AGE (Min 18 Years)
IBSRELA ORAL TABLET 50 MG (*tenapanor hcl*)	Non Preferred	PA; AGE (Min 18 Years)
LOTRONEX ORAL TABLET 0.5 MG, 1 MG (*alosetron hcl*)	Non Preferred	PA; AGE (Min 18 Years)
MOTEGRITY ORAL TABLET 1 MG, 2 MG (*prucalopride succinate*)	Non Preferred	PA; AGE (Min 18 Years)
RELISTOR ORAL TABLET 150 MG (*methylnaltrexone bromide*)	Non Preferred	PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
RELISTOR SUBCUTANEOUS SOLUTION 12 MG/0.6ML, 8 MG/0.4ML (*methylnaltrexone bromide*)	Non Preferred	PA; AGE (Min 18 Years)
SYMPROIC ORAL TABLET 0.2 MG (*naldemedine tosylate*)	Non Preferred	PA; AGE (Min 18 Years)
TRULANCE ORAL TABLET 3 MG (*plecanatide*)	Non Preferred	PA; AGE (Min 18 Years)
VIBERZI ORAL TABLET 100 MG, 75 MG (*eluxadoline*)	Non Preferred	PA; AGE (Min 18 Years)
GLUCAGON AGENTS [CLOSED CLASS]		
BAQSIMI ONE PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	Preferred	
BAQSIMI TWO PACK NASAL POWDER 3 MG/DOSE (*glucagon*)	Preferred	
PROGLYCEM ORAL SUSPENSION 50 MG/ML (*diazoxide*)	Preferred	
ZEGALOGUE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.6 MG/0.6ML (*dasiglucagon hcl*)	Preferred	
ZEGALOGUE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 0.6 MG/0.6ML (*dasiglucagon hcl*)	Preferred	
diazoxide oral suspension 50 mg/ml	Non Preferred	PA
glucagon emergency injection kit 1 mg	Non Preferred	PA
glucagon emergency injection solution reconstituted 1 mg/ml	Non Preferred	PA
GLUCAGEN HYPOKIT INJECTION SOLUTION RECONSTITUTED 1 MG (*glucagon hcl (rdna)*)	Non Preferred	PA
GVOKE HYPOPEN 1-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (*glucagon*)	Non Preferred	PA
GVOKE HYPOPEN 2-PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.5 MG/0.1ML, 1 MG/0.2ML (*glucagon*)	Non Preferred	PA
GVOKE KIT SUBCUTANEOUS SOLUTION 1 MG/0.2ML (*glucagon*)	Non Preferred	PA
GVOKE PFS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 1 MG/0.2ML (*glucagon*)	Non Preferred	PA
GLUCOCORTICOIDS: ORAL [OPEN CLASS]		
budesonide oral capsule delayed release particles 3 mg	Preferred	
dexamethasone oral elixir 0.5 mg/5ml	Preferred	
dexamethasone oral solution 0.5 mg/5ml	Preferred	
dexamethasone oral tablet 0.5 mg, 0.75 mg, 1 mg, 1.5 mg, 2 mg, 4 mg, 6 mg	Preferred	
hydrocortisone oral tablet 10 mg, 20 mg, 5 mg	Preferred	
methylprednisolone oral tablet 4 mg	Preferred	
methylprednisolone oral tablet therapy pack 4 mg	Preferred	
prednisolone oral solution 15 mg/5ml	Preferred	
prednisolone sodium phosphate oral solution 15 mg/5ml, 25 mg/5ml, 6.7 (5 base) mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
prednisone oral solution 5 mg/5ml	Preferred	
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
prednisone oral tablet therapy pack 10 mg (21), 10 mg (48), 5 mg (21), 5 mg (48)	Preferred	
DEXAMETHASONE INTENSOL ORAL CONCENTRATE 1 MG/ML (*dexamethasone*)	Preferred	
EMFLAZA ORAL SUSPENSION 22.75 MG/ML (*deflazacort*)	Preferred	SP; PA
EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG (*deflazacort*)	Preferred	SP; PA
PREDNISONE INTENSOL ORAL CONCENTRATE 5 MG/ML (*prednisone*)	Preferred	
cortisone acetate oral tablet 25 mg	Non Preferred	PA
deflazacort oral suspension 22.75 mg/ml	Non Preferred	SP; PA; AGE (Min 2 Years)
deflazacort oral tablet 18 mg, 30 mg, 6 mg	Non Preferred	SP; PA; AGE (Min 2 Years)
dexamethasone oral tablet therapy pack 1.5 mg (21), 1.5 mg (35), 1.5 mg (51)	Non Preferred	PA
methylprednisolone oral tablet 16 mg, 32 mg, 8 mg	Non Preferred	PA
prednisolone oral tablet 5 mg	Non Preferred	PA
prednisolone sodium phosphate oral solution 10 mg/5ml, 20 mg/5ml	Non Preferred	PA
prednisolone sodium phosphate oral tablet dispersible 10 mg, 15 mg, 30 mg	Non Preferred	PA
ALKINDI SPRINKLE ORAL CAPSULE SPRINKLE 0.5 MG, 1 MG, 2 MG, 5 MG (*hydrocortisone*)	Non Preferred	SP; PA; AGE (Max 16 Years)
CORTEF ORAL TABLET 10 MG, 20 MG, 5 MG (*hydrocortisone*)	Non Preferred	PA
EOHILIA ORAL SUSPENSION 2 MG/10ML (*budesonide*)	Non Preferred	PA; AGE (Min 11 Years)
HEMADY ORAL TABLET 20 MG (*dexamethasone*)	Non Preferred	PA
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG (*methylprednisolone*)	Non Preferred	PA
MEDROL ORAL TABLET THERAPY PACK 4 MG (*methylprednisolone*)	Non Preferred	PA
prednisolone (Millipred Oral Tablet 5 Mg)	Non Preferred	PA
RAYOS ORAL TABLET DELAYED RELEASE 1 MG, 2 MG, 5 MG (*prednisone*)	Non Preferred	PA
TAPERDEX 12-DAY ORAL TABLET THERAPY PACK 1.5 MG (49) (*dexamethasone*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
dexamethasone (Taperdex 6-Day Oral Tablet Therapy Pack 1.5 Mg, 1.5 Mg (21))	Non Preferred	PA
TAPERDEX 7-DAY ORAL TABLET THERAPY PACK 1.5 MG (27) (*dexamethasone*)	Non Preferred	PA
TARPEYO ORAL CAPSULE DELAYED RELEASE 4 MG (*budesonide*)	Non Preferred	PA
GROWTH HORMONE [CLOSED CLASS]		
GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE 0.2 MG, 0.4 MG, 0.6 MG, 0.8 MG, 1 MG, 1.2 MG, 1.4 MG, 1.6 MG, 1.8 MG, 2 MG (*somatropin*)	Preferred	SP; PA
GENOTROPIN SUBCUTANEOUS CARTRIDGE 12 MG, 5 MG (*somatropin*)	Preferred	SP; PA
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 30 MG/3ML, 5 MG/1.5ML (*somatropin*)	Preferred	SP; PA
HUMATROPE INJECTION CARTRIDGE 12 MG, 24 MG, 6 MG (*somatropin*)	Non Preferred	SP; PA
NGENLA SUBCUTANEOUS SOLUTION PEN-INJECTOR 24 MG/1.2ML, 60 MG/1.2ML (*somatrogon-ghla*)	Non Preferred	SP; PA; QL (4.8 ML per 28 days); AGE (Min 3 Years and Max 16 Years)
NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/2ML (*somatropin*)	Non Preferred	SP; PA
NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR 20 MG/2ML (*somatropin*)	Non Preferred	SP; PA
NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR 5 MG/2ML (*somatropin*)	Non Preferred	SP; PA
OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 10 MG/1.5ML, 5 MG/1.5ML (*somatropin*)	Non Preferred	SP; PA
OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED 5.8 MG (*somatropin*)	Non Preferred	SP; PA
SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG (*somatropin (non-refrigerated)*)	Non Preferred	SP; PA
SKYTROFA SUBCUTANEOUS CARTRIDGE 11 MG, 13.3 MG, 3 MG, 3.6 MG, 4.3 MG, 5.2 MG, 6.3 MG, 7.6 MG, 9.1 MG (*lonapegsomatropin-tcgd*)	Non Preferred	SP; PA; AGE (Min 1 Years and Max 16 Years)
SOGROYA SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML (*somapacitan-beco*)	Non Preferred	SP; PA; AGE (Min 2 Years)
ZOMACTON SUBCUTANEOUS SOLUTION RECONSTITUTED 10 MG, 5 MG (*somatropin*)	Non Preferred	SP; PA
H. PYLORI TREATMENT [OPEN CLASS]		
PYLERA ORAL CAPSULE 140-125-125 MG (*bis subcit-metronid-tetracyc*)	Preferred	
amoxicill-clarithro-lansopraz oral therapy pack 500 & 500 & 30 mg	Non Preferred	PA
bis subcit-metronid-tetracyc oral capsule 140-125-125 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
bismuth/metronidaz/tetracyclin oral capsule 140-125-125 mg	Non Preferred	PA
OMECLAMOX-PAK ORAL 500-500-20 MG (*amoxicill-clarithro-omeprazole*)	Non Preferred	PA
TALICIA ORAL CAPSULE DELAYED RELEASE 250-12.5-10 MG (*amoxicill-rifabutin-omeprazole*)	Non Preferred	PA
VOQUEZNA DUAL PAK ORAL THERAPY PACK 500-20 MG (*amoxicillin-vonoprazan*)	Non Preferred	PA; AGE (Min 18 Years)
VOQUEZNA ORAL TABLET 10 MG, 20 MG (*vonoprazan fumarate*)	Non Preferred	PA; AGE (Min 18 Years)
VOQUEZNA TRIPLE PAK ORAL THERAPY PACK 500-500-20 MG (*amoxicill-clarithro-vonoprazan*)	Non Preferred	PA; AGE (Min 18 Years)
HEMOPHILIA TREATMENT [CLOSED CLASS]		
adynovate intravenous solution reconstituted 1000 unit, 1500 unit, 2000 unit, 250 unit, 3000 unit, 500 unit, 750 unit	Preferred	SP
obizur intravenous solution reconstituted 500 unit	Preferred	SP
rixubis intravenous solution reconstituted 1000 unit, 2000 unit, 250 unit, 3000 unit, 500 unit	Preferred	SP
ADVATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*)	Preferred	SP
AFSTYLA INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact single chain*)	Preferred	SP
ALPHANATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor-vwf*)	Preferred	SP
ALPHANINE SD INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*coagulation factor ix*)	Preferred	SP
ALPROLIX INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*coagulation factor ix (rfixfc)*)	Preferred	SP
ALTUVIIIO INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact fc-vwf-xten-ehtl*)	Preferred	SP
BENEFIX INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	Preferred	SP
COAGADEX INTRAVENOUS SOLUTION RECONSTITUTED 250 UNIT, 500 UNIT (*coagulation factor x (human)*)	Preferred	SP
CORIFACT INTRAVENOUS KIT 1000-1600 UNIT (*factor xiii concentrate human*)	Preferred	SP
ELOCTATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT, 5000 UNIT, 6000 UNIT, 750 UNIT (*antihem fact (bdd-rfviiifc)*)	Preferred	SP

Drug Name	Formulary Status	Requirements/Limits
ESPEROCT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*antihemoph fact rcmb gpeg-exei*)	Preferred	SP
FEIBA INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2500 UNIT, 500 UNIT (*antiinhibitor coagulant cmplx*)	Preferred	SP
HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 12 MG/0.4ML, 150 MG/ML, 30 MG/ML, 300 MG/2ML, 60 MG/0.4ML (*emicizumab-kxwh*)	Preferred	SP
HEMOFIL M INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1700 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*)	Preferred	SP
HUMATE-P INTRAVENOUS SOLUTION RECONSTITUTED 1000-2400 UNIT, 250-600 UNIT, 500-1200 UNIT (*antihemophilic factor-vwf*)	Preferred	SP
IDELVION INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3500 UNIT, 500 UNIT (*coagulation factor ix (rix-fp)*)	Preferred	SP
IXINITY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix (recomb)*)	Preferred	SP
JIVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*ahf (bdd-rfviii peg-aucl)*)	Preferred	SP
KOATE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 250 UNIT, 500 UNIT (*antihemophilic factor*)	Preferred	SP
KOATE-DVI INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT (*antihemophilic factor*)	Preferred	SP
KOGENATE FS INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihem factor recomb (rfviii)*)	Preferred	SP
KOVALTRY INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil factor (rahf-pfm)*)	Preferred	SP
NOVOEIGHT INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihemophil fact bd truncated*)	Preferred	SP
NOVOSEVEN RT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 2 MG, 5 MG, 8 MG (*coagulation factor viia recomb*)	Preferred	SP
NUWIQ INTRAVENOUS KIT 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*)	Preferred	SP
NUWIQ INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 2000 UNIT, 250 UNIT, 2500 UNIT, 3000 UNIT, 4000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,sim)*)	Preferred	SP
PROFILNINE INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 1500 UNIT, 500 UNIT (*factor ix complex*)	Preferred	SP
REBINYN INTRAVENOUS SOLUTION RECONSTITUTED 1000 UNIT, 2000 UNIT, 3000 UNIT, 500 UNIT (*coagulation factor ix glycopeg*)	Preferred	SP

Drug Name	Formulary Status	Requirements/Limits
RECOMBINATE INTRAVENOUS SOLUTION RECONSTITUTED 1241-1800 UNIT, 1801-2400 UNIT, 220-400 UNIT, 401-800 UNIT, 801-1240 UNIT (*antihem factor recomb (rfviii)*)	Preferred	SP
SEVENFACT INTRAVENOUS SOLUTION RECONSTITUTED 1 MG, 5 MG (*coagulation factor viia-jncw*)	Preferred	SP
TRETTEN INTRAVENOUS SOLUTION RECONSTITUTED 2500 UNIT (*coagulation factor xiii a-sub*)	Preferred	SP
VONVENDI INTRAVENOUS SOLUTION RECONSTITUTED 1300 UNIT, 650 UNIT (*von willebrand factor (recomb)*)	Preferred	SP
WILATE INTRAVENOUS KIT 1000-1000 UNIT, 500-500 UNIT (*antihemophilic factor-vwf*)	Preferred	SP
XYNTHA INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*)	Preferred	SP
XYNTHA SOLOFUSE INTRAVENOUS KIT 1000 UNIT, 2000 UNIT, 250 UNIT, 3000 UNIT, 500 UNIT (*antihem fact (bdd-rfviii,mor)*)	Preferred	SP
HEPATITIS B [CLOSED CLASS]		
entecavir oral tablet 0.5 mg, 1 mg	Preferred	QL (1 EA per 1 day); AGE (Min 2 Years)
adefovir dipivoxil oral tablet 10 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 12 Years)
lamivudine oral tablet 100 mg	Non Preferred	PA; QL (2 EA per 1 day)
BARACLUDE ORAL SOLUTION 0.05 MG/ML (*entecavir*)	Non Preferred	PA; QL (20 ML per 1 day); AGE (Min 2 Years)
BARACLUDE ORAL TABLET 0.5 MG, 1 MG (*entecavir*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 2 Years)
HEPSERA ORAL TABLET 10 MG (*adefovir dipivoxil*)	Non Preferred	PA
VEMLIDY ORAL TABLET 25 MG (*tenofovir alafenamide fumarate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years)
HEPATITIS C AGENTS [CLOSED CLASS]		
sofosbuvir-velpatasvir oral tablet 400-100 mg	Preferred	SP; QL (Max 84 days of therapy per lifetime); AGE (Min 3 Years); Max 84-day supply per 1 Fill
MAVYRET ORAL PACKET 50-20 MG (*glecaprevir-pibrentasvir*)	Preferred	SP; QL (Max 84 days of therapy per lifetime); AGE (Min 3 Years); Max 84-day supply per 1 Fill
MAVYRET ORAL TABLET 100-40 MG (*glecaprevir-pibrentasvir*)	Preferred	SP; QL (Max 84 days of therapy per lifetime); AGE (Min 12 Years); Max 84-day supply per 1 Fill
ledipasvir-sofosbuvir oral tablet 90-400 mg	Non Preferred	SP; PA; AGE (Min 3 Years)

Drug Name	Formulary Status	Requirements/Limits
EPCLUSA ORAL PACKET 150-37.5 MG, 200-50 MG (*sofosbuvir-velpatasvir*)	Non Preferred	SP; PA; AGE (Min 3 Years)
EPCLUSA ORAL TABLET 200-50 MG (*sofosbuvir-velpatasvir*)	Non Preferred	SP; PA; AGE (Min 3 Years)
EPCLUSA ORAL TABLET 400-100 MG (*sofosbuvir-velpatasvir*)	Non Preferred	SP; PA; QL (Max 84 days of therapy per lifetime); AGE (Min 3 Years); Max 84-day supply per 1 Fill
HARVONI ORAL PACKET 33.75-150 MG, 45-200 MG (*ledipasvir-sofosbuvir*)	Non Preferred	SP; PA; AGE (Min 3 Years and Max 16 Years)
HARVONI ORAL TABLET 45-200 MG (*ledipasvir-sofosbuvir*)	Non Preferred	SP; PA; AGE (Min 3 Years and Max 16 Years)
HARVONI ORAL TABLET 90-400 MG (*ledipasvir-sofosbuvir*)	Non Preferred	SP; PA; AGE (Min 3 Years)
PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML (*peginterferon alfa-2a*)	Non Preferred	SP; PA
PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 180 MCG/0.5ML (*peginterferon alfa-2a*)	Non Preferred	SP; PA
SOVALDI ORAL PACKET 150 MG, 200 MG (*sofosbuvir*)	Non Preferred	SP; PA; AGE (Max 16 Years)
SOVALDI ORAL TABLET 200 MG (*sofosbuvir*)	Non Preferred	SP; PA; AGE (Max 16 Years)
SOVALDI ORAL TABLET 400 MG (*sofosbuvir*)	Non Preferred	SP; PA
VOSEVI ORAL TABLET 400-100-100 MG (*sofosbuv-velpatasv-voxilaprev*)	Non Preferred	SP; PA
ZEPATIER ORAL TABLET 50-100 MG (*elbasvir-grazoprevir*)	Non Preferred	SP; PA
HEREDITARY ANGIOEDEMA (HAE) AGENTS [OPEN CLASS]		
icatibant acetate subcutaneous solution prefilled syringe 30 mg/3ml	Preferred	SP; PA; AGE (Min 18 Years)
BERINERT INTRAVENOUS KIT 500 UNIT (*c1 esterase inhibitor (human)*)	Preferred	SP; PA; QL (4 EA per 1 Fill); AGE (Min 6 Years)
KALBITOR SUBCUTANEOUS SOLUTION 10 MG/ML (*ecallantide*)	Preferred	SP; PA; QL (6 ML per 1 Fill); AGE (Min 12 Years)
icatibant acetate (Sajazir Subcutaneous Solution Prefilled Syringe 30 Mg/3Ml)	Preferred	SP; PA; AGE (Min 18 Years)
FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/3ML (*icatibant acetate*)	Non Preferred	SP; PA; AGE (Min 18 Years)
HAEGARDA SUBCUTANEOUS SOLUTION RECONSTITUTED 2000 UNIT, 3000 UNIT (*c1 esterase inhibitor (human)*)	Non Preferred	SP; PA; AGE (Min 12 Years)
ORLADEYO ORAL CAPSULE 110 MG, 150 MG (*berotralstat hcl*)	Non Preferred	SP; PA; AGE (Min 12 Years)
RUCONEST INTRAVENOUS SOLUTION RECONSTITUTED 2100 UNIT (*c1 esterase inhibitor (recomb)*)	Non Preferred	SP; PA; AGE (Min 13 Years)

Drug Name	Formulary Status	Requirements/Limits
TAKHZYRO SUBCUTANEOUS SOLUTION 300 MG/2ML (*lanadelumab-flyo*)	Non Preferred	SP; PA; AGE (Min 2 Years)
TAKHZYRO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML (*lanadelumab-flyo*)	Non Preferred	SP; PA; AGE (Min 2 Years)
HERPES: ORAL [OPEN CLASS]		
acyclovir oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
acyclovir oral suspension 200 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
acyclovir oral tablet 400 mg, 800 mg	Preferred	90-day fill allowed after two 1-month fills
famciclovir oral tablet 125 mg, 250 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
valacyclovir hcl oral tablet 1 gm, 500 mg	Preferred	90-day fill allowed after two 1-month fills
SITAVIG BUCCAL TABLET 50 MG (*acyclovir*)	Non Preferred	PA
VALTREX ORAL TABLET 1 GM, 500 MG (*valacyclovir hcl*)	Non Preferred	PA
HERPES: TOPICAL [OPEN CLASS]		
acyclovir external cream 5 %	Preferred	
acyclovir external ointment 5 %	Preferred	
docosanol external cream 10 %	Preferred	
ft docosanol external cream 10 %	Preferred	
gnp docosanol external cream 10 %	Preferred	
penciclovir external cream 1 %	Non Preferred	PA
DENAVIR EXTERNAL CREAM 1 % (*penciclovir*)	Non Preferred	PA
XERESE EXTERNAL CREAM 5-1 % (*acyclovir-hydrocortisone*)	Non Preferred	PA
ZOVIRAX EXTERNAL CREAM 5 % (*acyclovir*)	Non Preferred	PA
ZOVIRAX EXTERNAL OINTMENT 5 % (*acyclovir*)	Non Preferred	PA
HISTAMINE-2 RECEPTOR ANTAGONISTS (H-2 RA) [OPEN CLASS]		
acid reducer maximum strength oral tablet 20 mg	Preferred	90-day fill allowed after two 1-month fills
acid reducer oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
famotidine maximum strength oral tablet 20 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
famotidine oral suspension reconstituted 40 mg/5ml	Preferred	PA (Eligible for auto-PA approval); AGE (Max 11 Years); 90-day fill allowed after two 1-month fills
famotidine oral tablet 10 mg, 40 mg	Preferred	90-day fill allowed after two 1-month fills
famotidine orig st oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
famotidine tablet 20 mg oral (otc)	Preferred	90-day fill allowed after two 1-month fills
famotidine tablet 20 mg oral (rx)	Preferred	90-day fill allowed after two 1-month fills
ft acid reducer max strength oral tablet 20 mg	Preferred	90-day fill allowed after two 1-month fills
ft acid reducer oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
gnp acid reducer max st oral tablet 20 mg	Preferred	90-day fill allowed after two 1-month fills
gnp acid reducer oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
heartburn relief max st oral tablet 20 mg	Preferred	90-day fill allowed after two 1-month fills
heartburn relief oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
sm acid reducer max st oral tablet 20 mg	Preferred	90-day fill allowed after two 1-month fills
sm acid reducer oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
acid reducer complete oral tablet chewable 10-800-165 mg	Non Preferred	PA
cimetidine hcl oral solution 300 mg/5ml	Non Preferred	PA
cimetidine oral tablet 200 mg, 300 mg, 400 mg, 800 mg	Non Preferred	PA
ft acid reducer + antacid oral tablet chewable 10-800-165 mg	Non Preferred	PA
goodsense dual action complete oral tablet chewable 10-800-165 mg	Non Preferred	PA
hm dual action complete oral tablet chewable 10-800-165 mg	Non Preferred	PA
nizatidine oral capsule 150 mg, 300 mg	Non Preferred	PA
PEPCID ORAL TABLET 20 MG, 40 MG (*famotidine*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
HIV/AIDS [CLOSED CLASS]		
abacavir sulfate oral solution 20 mg/ml	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
abacavir sulfate oral tablet 300 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
abacavir sulfate-lamivudine oral tablet 600-300 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
atazanavir sulfate oral capsule 150 mg, 300 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
atazanavir sulfate oral capsule 200 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
darunavir oral tablet 600 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
darunavir oral tablet 800 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
efavirenz oral tablet 600 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
efavirenz-emtricitab-tenofo df oral tablet 600-200-300 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
emtricitabine oral capsule 200 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
emtricitabine-tenofovir df oral tablet 100-150 mg, 133-200 mg, 167-250 mg	Preferred	QL (1 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
emtricitabine-tenofovir df oral tablet 200-300 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
etravirine oral tablet 100 mg, 200 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
fosamprenavir calcium oral tablet 700 mg	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
lamivudine oral solution 10 mg/ml	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
lamivudine oral tablet 150 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
lamivudine oral tablet 300 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
lamivudine-zidovudine oral tablet 150-300 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
lopinavir-ritonavir oral solution 400-100 mg/5ml	Preferred	QL (10 ML per 1 day); 90-day fill allowed after two 1-month fills
lopinavir-ritonavir oral tablet 100-25 mg	Preferred	QL (10 EA per 1 day); 90-day fill allowed after two 1-month fills
lopinavir-ritonavir oral tablet 200-50 mg	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
maraviroc oral tablet 150 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
maraviroc oral tablet 300 mg	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
nevirapine er oral tablet extended release 24 hour 100 mg, 400 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
nevirapine oral suspension 50 mg/5ml	Preferred	QL (40 ML per 1 day); 90-day fill allowed after two 1-month fills
nevirapine oral tablet 200 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
ritonavir oral tablet 100 mg	Preferred	QL (12 EA per 1 day); 90-day fill allowed after two 1-month fills
tenofovir disoproxil fumarate oral tablet 300 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
triumeq pd oral tablet soluble 60-5-30 mg	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
zidovudine oral capsule 100 mg	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills
zidovudine oral syrup 50 mg/5ml	Preferred	QL (60 ML per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
zidovudine oral tablet 300 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
APRETUDE INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 MG/3ML (*cabotegravir*)	Preferred	QL (3 ML per 28 days); Max 56-day supply per 1 Fill
BIKTARVY ORAL TABLET 30-120-15 MG (*bictegravir-emtricitab-tenofov*)	Preferred	QL (1 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
BIKTARVY ORAL TABLET 50-200-25 MG (*bictegravir-emtricitab-tenofov*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 400 & 600 MG/2ML (*cabotegravir & rilpivirine*)	Preferred	QL (12 ML per 84 days); 90-day fill allowed after two 1-month fills
CABENUVA INTRAMUSCULAR SUSPENSION EXTENDED RELEASE 600 & 900 MG/3ML (*cabotegravir & rilpivirine*)	Preferred	QL (6 ML per 28 days); 90-day fill allowed after two 1-month fills
CIMDUO ORAL TABLET 300-300 MG (*lamivudine-tenofovir*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
COMPLERA ORAL TABLET 200-25-300 MG (*emtricitab-rilpivir-tenofovir*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
DELSTRIGO ORAL TABLET 100-300-300 MG (*doravirin-lamivudin-tenofov df*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
DESCOVY ORAL TABLET 120-15 MG, 200-25 MG (*emtricitabine-tenofovir af*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
DOVATO ORAL TABLET 50-300 MG (*dolutegravir-lamivudine*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
EDURANT ORAL TABLET 25 MG (*rilpivirine hcl*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
EMTRIVA ORAL CAPSULE 200 MG (*emtricitabine*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
EMTRIVA ORAL SOLUTION 10 MG/ML (*emtricitabine*)	Preferred	QL (24 ML per 1 day); 90-day fill allowed after two 1-month fills
EPIVIR ORAL SOLUTION 10 MG/ML (*lamivudine*)	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
EVOTAZ ORAL TABLET 300-150 MG (*atazanavir-cobicistat*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
FUZEON SUBCUTANEOUS SOLUTION RECONSTITUTED 90 MG (*enfuvirtide*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
GENVOYA ORAL TABLET 150-150-200-10 MG (*elviteg-cobic-emtricit-tenofaf*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
INTELENCE ORAL TABLET 100 MG, 200 MG (*etravirine*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
INTELENCE ORAL TABLET 25 MG (*etravirine*)	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
ISENTRESS HD ORAL TABLET 600 MG (*raltegravir potassium*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
ISENTRESS ORAL PACKET 100 MG (*raltegravir potassium*)	Preferred	QL (2 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
ISENTRESS ORAL TABLET 400 MG (*raltegravir potassium*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
ISENTRESS ORAL TABLET CHEWABLE 100 MG, 25 MG (*raltegravir potassium*)	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
JULUCA ORAL TABLET 50-25 MG (*dolutegravir-rilpivirine*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
LEXIVA ORAL TABLET 700 MG (*fosamprenavir calcium*)	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
NORVIR ORAL PACKET 100 MG (*ritonavir*)	Preferred	QL (12 EA per 1 day); 90-day fill allowed after two 1-month fills
ODEFSEY ORAL TABLET 200-25-25 MG (*emtricitab-rilpivir-tenofov af*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
PIFELTRO ORAL TABLET 100 MG (*doravirine*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
PREZCOBIX ORAL TABLET 800-150 MG (*darunavir-cobicistat*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
RETROVIR ORAL CAPSULE 100 MG (*zidovudine*)	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
REYATAZ ORAL PACKET 50 MG (*atazanavir sulfate*)	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills
RUKOBIA ORAL TABLET EXTENDED RELEASE 12 HOUR 600 MG (*fostemsavir tromethamine*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL SOLUTION 20 MG/ML (*maraviroc*)	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 150 MG (*maraviroc*)	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 25 MG (*maraviroc*)	Preferred	QL (8 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 300 MG (*maraviroc*)	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
SELZENTRY ORAL TABLET 75 MG (*maraviroc*)	Preferred	QL (2 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
STRIBILD ORAL TABLET 150-150-200-300 MG (*elviteg-cobic-emtricit-tenofdf*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
SUNLENCA ORAL TABLET THERAPY PACK 4 X 300 MG, 5 X 300 MG (*lenacapavir sodium*)	Preferred	AGE (Min 18 Years)
SUNLENCA SUBCUTANEOUS SOLUTION 463.5 MG/1.5ML (*lenacapavir sodium*)	Preferred	AGE (Min 18 Years)
SYMFI LO ORAL TABLET 400-300-300 MG (*efavirenz-lamivudine-tenofovir*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
SYMFI ORAL TABLET 600-300-300 MG (*efavirenz-lamivudine-tenofovir*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
SYMTUZA ORAL TABLET 800-150-200-10 MG (*darun-cobic-emtricit-tenofaf*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
TIVICAY ORAL TABLET 10 MG, 25 MG (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
TIVICAY ORAL TABLET 50 MG (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
TIVICAY PD ORAL TABLET SOLUBLE 5 MG (*dolutegravir sodium*)	Preferred	QL (6 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
TRIUMEQ ORAL TABLET 600-50-300 MG (*abacavir-dolutegravir-lamivud*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
TRUVADA ORAL TABLET 100-150 MG, 133-200 MG, 167-250 MG (*emtricitabine-tenofovir df*)	Preferred	QL (1 EA per 1 day); AGE (Max 16 Years); 90-day fill allowed after two 1-month fills
TRUVADA ORAL TABLET 200-300 MG (*emtricitabine-tenofovir df*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
TYBOST ORAL TABLET 150 MG (*cobicistat*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
VIREAD ORAL POWDER 40 MG/GM (*tenofovir disoproxil fumarate*)	Preferred	QL (1 GM per 1 day); 90-day fill allowed after two 1-month fills
ZIAGEN ORAL SOLUTION 20 MG/ML (*abacavir sulfate*)	Preferred	QL (30 ML per 1 day); 90-day fill allowed after two 1-month fills
didanosine oral capsule delayed release 250 mg, 400 mg	Non Preferred	PA; QL (1 EA per 1 day)
efavirenz oral capsule 200 mg	Non Preferred	PA; QL (2 EA per 1 day)
efavirenz oral capsule 50 mg	Non Preferred	PA; QL (3 EA per 1 day)
efavirenz-lamivudine-tenofovir oral tablet 400-300-300 mg, 600-300-300 mg	Non Preferred	PA; QL (1 EA per 1 day)
stavudine oral capsule 40 mg	Non Preferred	PA; QL (2 EA per 1 day)
APTIVUS ORAL CAPSULE 250 MG (*tipranavir*)	Non Preferred	PA; QL (4 EA per 1 day)
ATRIPLA ORAL TABLET 600-200-300 MG (*efavirenz-emtricitab-tenofo df*)	Non Preferred	PA; QL (1 EA per 1 day)
COMBIVIR ORAL TABLET 150-300 MG (*lamivudine-zidovudine*)	Non Preferred	PA; QL (2 EA per 1 day)
EPIVIR ORAL TABLET 150 MG (*lamivudine*)	Non Preferred	PA; QL (2 EA per 1 day)
EPIVIR ORAL TABLET 300 MG (*lamivudine*)	Non Preferred	PA; QL (1 EA per 1 day)
EPZICOM ORAL TABLET 600-300 MG (*abacavir sulfate-lamivudine*)	Non Preferred	PA; QL (1 EA per 1 day)
KALETRA ORAL SOLUTION 400-100 MG/5ML (*lopinavir-ritonavir*)	Non Preferred	PA; QL (10 ML per 1 day)

Drug Name	Formulary Status	Requirements/Limits
KALETRA ORAL TABLET 100-25 MG (*lopinavir-ritonavir*)	Non Preferred	PA; QL (10 EA per 1 day)
KALETRA ORAL TABLET 200-50 MG (*lopinavir-ritonavir*)	Non Preferred	PA; QL (4 EA per 1 day)
LEXIVA ORAL SUSPENSION 50 MG/ML (*fosamprenavir calcium*)	Non Preferred	PA; QL (56 ML per 1 day)
NORVIR ORAL TABLET 100 MG (*ritonavir*)	Non Preferred	PA; QL (12 EA per 1 day)
PREZISTA ORAL SUSPENSION 100 MG/ML (*darunavir*)	Non Preferred	PA; QL (12 ML per 1 day)
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG (*darunavir*)	Non Preferred	PA; QL (2 EA per 1 day)
PREZISTA ORAL TABLET 800 MG (*darunavir*)	Non Preferred	PA; QL (1 EA per 1 day)
RETROVIR ORAL SYRUP 50 MG/5ML (*zidovudine*)	Non Preferred	PA; QL (60 ML per 1 day)
REYATAZ ORAL CAPSULE 200 MG (*atazanavir sulfate*)	Non Preferred	PA; QL (2 EA per 1 day)
REYATAZ ORAL CAPSULE 300 MG (*atazanavir sulfate*)	Non Preferred	PA; QL (1 EA per 1 day)
TRIZIVIR ORAL TABLET 300-150-300 MG (*abacavir-lamivudine-zidovudine*)	Non Preferred	PA; QL (2 EA per 1 day)
TROGARZO INTRAVENOUS SOLUTION 200 MG/1.33ML (*ibalizumab-uiyk*)	Non Preferred	PA
VIRACEPT ORAL TABLET 250 MG (*nelfinavir mesylate*)	Non Preferred	PA; QL (10 EA per 1 day)
VIRACEPT ORAL TABLET 625 MG (*nelfinavir mesylate*)	Non Preferred	PA; QL (4 EA per 1 day)
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG, 300 MG (*tenofovir disoproxil fumarate*)	Non Preferred	PA; QL (1 EA per 1 day)
IMMUNOMODULATORS ATOPIC DERMATITIS [CLOSED CLASS]		
tacrolimus external ointment 0.03 %	Preferred	PA (Eligible for auto-PA approval); QL (30 GM per 30 days); AGE (Min 2 Years)
tacrolimus external ointment 0.1 %	Preferred	PA (Eligible for auto-PA approval); QL (30 GM per 30 days); AGE (Min 16 Years)
ADBRY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML (*tralokinumab-ldrm*)	Preferred	SP; PA; QL (4 ML per 28 days); AGE (Min 18 Years)
DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML, 300 MG/2ML (*dupilumab*)	Preferred	SP; PA (Eligible for auto-PA approval)
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML (*dupilumab*)	Preferred	SP; PA
DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML (*dupilumab*)	Preferred	SP; PA (Eligible for auto-PA approval)

Drug Name	Formulary Status	Requirements/Limits
ELIDEL EXTERNAL CREAM 1 % (*pimecrolimus*)	Preferred	PA (Eligible for auto-PA approval); QL (30 GM per 30 days); AGE (Min 2 Years)
EUCRISA EXTERNAL OINTMENT 2 % (*crisaborole*)	Preferred	PA (Eligible for auto-PA approval); QL (300 GM per 365 days); AGE (Min 3 months)
pimecrolimus external cream 1 %	Non Preferred	PA; QL (30 GM per 30 days); AGE (Min 2 Years)
OPZELURA EXTERNAL CREAM 1.5 % (*ruxolitinib phosphate*)	Non Preferred	PA; QL (240 GM per 30 days); AGE (Min 12 Years)
ZORYVE EXTERNAL FOAM 0.3 % (*roflumilast (antiseborrheic)*)	Non Preferred	PA; AGE (Min 6 Years)
IMMUNOMODULATORS: ASTHMA [CLOSED CLASS]		
FASENRA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 30 MG/ML (*benralizumab*)	Preferred	SP; PA; AGE (Min 6 Years)
FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 30 MG/ML (*benralizumab*)	Preferred	SP; PA; AGE (Min 6 Years)
XOLAIR SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (*omalizumab*)	Preferred	SP; PA; AGE (Min 1 Years)
XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 300 MG/2ML, 75 MG/0.5ML (*omalizumab*)	Preferred	SP; PA; AGE (Min 1 Years)
XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED 150 MG (*omalizumab*)	Preferred	SP; PA; AGE (Min 1 Years)
CINQAIR INTRAVENOUS SOLUTION 100 MG/10ML (*reslizumab*)	Non Preferred	SP; PA; AGE (Min 18 Years)
NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML (*mepolizumab*)	Non Preferred	SP; PA; AGE (Min 12 Years)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML (*mepolizumab*)	Non Preferred	SP; PA; AGE (Min 12 Years)
NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML (*mepolizumab*)	Non Preferred	SP; PA; AGE (Min 6 Years and Max 11 Years)
NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED 100 MG (*mepolizumab*)	Non Preferred	SP; PA; AGE (Min 6 Years)
TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 210 MG/1.91ML (*tezepelumab-ekko*)	Non Preferred	SP; PA; AGE (Min 12 Years)
TEZSPIRE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 210 MG/1.91ML (*tezepelumab-ekko*)	Non Preferred	SP; PA; AGE (Min 12 Years)
INFLUENZA [OPEN CLASS]		
oseltamivir phosphate oral capsule 30 mg, 45 mg, 75 mg	Preferred	
oseltamivir phosphate oral suspension reconstituted 6 mg/ml	Preferred	
rimantadine hcl oral tablet 100 mg	Non Preferred	PA
RELENZA DISKHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 5 MG/ACT (*zanamivir*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
TAMIFLU ORAL CAPSULE 30 MG, 45 MG, 75 MG (*oseltamivir phosphate*)	Non Preferred	PA
TAMIFLU ORAL SUSPENSION RECONSTITUTED 6 MG/ML (*oseltamivir phosphate*)	Non Preferred	PA
XOFLUZA (40 MG DOSE) ORAL TABLET THERAPY PACK 1 X 40 MG (*baloxavir marboxil*)	Non Preferred	PA
XOFLUZA (80 MG DOSE) ORAL TABLET THERAPY PACK 1 X 80 MG (*baloxavir marboxil*)	Non Preferred	PA
INHALED CORTICOSTEROIDS: COMBINATIONS [CLOSED CLASS]		
ADVAIR DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100-50 MCG/ACT, 250-50 MCG/ACT, 500-50 MCG/ACT (*fluticasone-salmeterol*)	Preferred	90-day fill allowed after two 1-month fills
ADVAIR HFA INHALATION AEROSOL 115-21 MCG/ACT, 230-21 MCG/ACT, 45-21 MCG/ACT (*fluticasone-salmeterol*)	Preferred	90-day fill allowed after two 1-month fills
DULERA INHALATION AEROSOL 100-5 MCG/ACT, 200-5 MCG/ACT (*mometasone furo-formoterol fum*)	Preferred	90-day fill allowed after two 1-month fills
DULERA INHALATION AEROSOL 50-5 MCG/ACT (*mometasone furo-formoterol fum*)	Preferred	AGE (Max 12 Years); 90-day fill allowed after two 1-month fills
SYMBICORT INHALATION AEROSOL 160-4.5 MCG/ACT, 80-4.5 MCG/ACT (*budesonide-formoterol fumarate*)	Preferred	90-day fill allowed after two 1-month fills
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	Preferred	90-day fill allowed after two 1-month fills
TRELEGY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 200-62.5-25 MCG/ACT (*fluticasone-umeclidin-vilant*)	Preferred	
budesonide-formoterol fumarate inhalation aerosol 160-4.5 mcg/act, 80-4.5 mcg/act	Non Preferred	PA
fluticasone furoate-vilanterol inhalation aerosol powder breath activated 100-25 mcg/act, 200-25 mcg/act	Non Preferred	PA
fluticasone-salmeterol inhalation aerosol 115-21 mcg/act, 230-21 mcg/act, 45-21 mcg/act	Non Preferred	PA
fluticasone-salmeterol inhalation aerosol powder breath activated 100-50 mcg/act, 113-14 mcg/act, 232-14 mcg/act, 250-50 mcg/act, 500-50 mcg/act, 55-14 mcg/act	Non Preferred	PA
AIRDUO DIGIHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT, 232-14 MCG/ACT, 55-14 MCG/ACT (*fluticasone-salmeterol(sensor)*)	Non Preferred	PA
AIRDUO RESPICLICK 113/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 113-14 MCG/ACT (*fluticasone-salmeterol*)	Non Preferred	PA
AIRDUO RESPICLICK 232/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 232-14 MCG/ACT (*fluticasone-salmeterol*)	Non Preferred	PA
AIRDUO RESPICLICK 55/14 INHALATION AEROSOL POWDER BREATH ACTIVATED 55-14 MCG/ACT (*fluticasone-salmeterol*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
AIRSUPRA INHALATION AEROSOL 90-80 MCG/ACT (*albuterol-budesonide*)	Non Preferred	PA; AGE (Min 18 Years)
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100-25 MCG/ACT, 200-25 MCG/ACT (*fluticasone furoate-vilanterol*)	Non Preferred	PA
BREO ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50-25 MCG/INH (*fluticasone furoate-vilanterol*)	Non Preferred	PA; AGE (Max 11 Years)
budesonide-formoterol fumarate (Breyna Inhalation Aerosol 160-4.5 Mcg/Act, 80-4.5 Mcg/Act)	Non Preferred	PA
BREZTRI AEROSPHERE INHALATION AEROSOL 160-9-4.8 MCG/ACT (*budeson-glycopyrrol-formoterol*)	Non Preferred	PA
fluticasone-salmeterol (Wixela Inhub Inhalation Aerosol Powder Breath Activated 100-50 Mcg/Act, 250-50 Mcg/Act, 500-50 Mcg/Act)	Non Preferred	PA
INHALED CORTICOSTEROIDS: MDIS [CLOSED CLASS]		
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT, 80 MCG/ACT (*ciclesonide*)	Preferred	
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 200 MCG/ACT (*fluticasone furoate*)	Preferred	90-day fill allowed after two 1-month fills
ARNUITY ELLIPTA INHALATION AEROSOL POWDER BREATH ACTIVATED 50 MCG/ACT (*fluticasone furoate*)	Preferred	AGE (Max 11 Years); 90-day fill allowed after two 1-month fills
ASMANEX (120 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (*mometasone furoate*)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX (14 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (*mometasone furoate*)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX (30 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 110 MCG/ACT, 220 MCG/ACT (*mometasone furoate*)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX (60 METERED DOSES) INHALATION AEROSOL POWDER BREATH ACTIVATED 220 MCG/ACT (*mometasone furoate*)	Preferred	90-day fill allowed after two 1-month fills
ASMANEX HFA INHALATION AEROSOL 100 MCG/ACT, 200 MCG/ACT (*mometasone furoate*)	Preferred	
ASMANEX HFA INHALATION AEROSOL 50 MCG/ACT (*mometasone furoate*)	Preferred	AGE (Max 12 Years)
FLOVENT DISKUS INHALATION AEROSOL POWDER BREATH ACTIVATED 100 MCG/ACT, 250 MCG/ACT, 50 MCG/ACT (*fluticasone propionate (inhal)*)	Preferred	90-day fill allowed after two 1-month fills
FLOVENT HFA INHALATION AEROSOL 110 MCG/ACT, 220 MCG/ACT, 44 MCG/ACT (*fluticasone propionate hfa*)	Preferred	90-day fill allowed after two 1-month fills
PULMICORT FLEXHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 180 MCG/ACT, 90 MCG/ACT (*budesonide*)	Preferred	90-day fill allowed after two 1-month fills
QVAR REDIHALER INHALATION AEROSOL BREATH ACTIVATED 40 MCG/ACT, 80 MCG/ACT (*beclomethasone diprop hfa*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
fluticasone propionate diskus inhalation aerosol powder breath activated 100 mcg/act, 250 mcg/act, 50 mcg/act	Non Preferred	PA
fluticasone propionate hfa inhalation aerosol 110 mcg/act, 220 mcg/act, 44 mcg/act	Non Preferred	PA
ARMONAIR DIGIHALER INHALATION AEROSOL POWDER BREATH ACTIVATED 113 MCG/ACT, 232 MCG/ACT, 55 MCG/ACT (*fluticasone propionate(sensor)*)	Non Preferred	PA
INHALED CORTICOSTEROIDS: NEBULIZER SOLUTION [CLOSED CLASS]		
budesonide inhalation suspension 0.25 mg/2ml, 0.5 mg/2ml, 1 mg/2ml	Preferred	AGE (Max 8 Years); 90-day fill allowed after two 1-month fills
PULMICORT INHALATION SUSPENSION 0.25 MG/2ML, 0.5 MG/2ML, 1 MG/2ML (*budesonide*)	Non Preferred	PA; AGE (Max 8 Years)
INSULINS: INSULIN MIX [OPEN CLASS]		
insulin asp prot & asp flexpen subcutaneous suspension pen-injector (70-30) 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin aspart prot & aspart subcutaneous suspension (70-30) 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
HUMALOG MIX 50/50 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (50-50) 100 UNIT/ML (*insulin lispro prot & lispro*)	Preferred	
HUMALOG MIX 75/25 SUBCUTANEOUS SUSPENSION (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN 70/30 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Preferred	90-day fill allowed after two 1-month fills
insulin lispro prot & lispro subcutaneous suspension pen-injector (75-25) 100 unit/ml	Non Preferred	PA
HUMALOG MIX 75/25 KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (75-25) 100 UNIT/ML (*insulin lispro prot & lispro*)	Non Preferred	PA
NOVOLIN 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Non Preferred	PA
NOVOLIN 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Non Preferred	PA
NOVOLIN 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Non Preferred	PA
NOVOLIN 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin nph isophane & regular*)	Non Preferred	PA
NOVOLOG 70/30 FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
NOVOLOG MIX 70/30 FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Non Preferred	PA
NOVOLOG MIX 70/30 RELION SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Non Preferred	PA
NOVOLOG MIX 70/30 SUBCUTANEOUS SUSPENSION (70-30) 100 UNIT/ML (*insulin aspart prot & aspart*)	Non Preferred	PA
INSULINS: INSULIN N [OPEN CLASS]		
HUMULIN N KWIKPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLIN N FLEXPEN RELION SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	Non Preferred	PA
NOVOLIN N FLEXPEN SUBCUTANEOUS SUSPENSION PEN-INJECTOR 100 UNIT/ML (*insulin nph human (isophane)*)	Non Preferred	PA
NOVOLIN N RELION SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	Non Preferred	PA
NOVOLIN N SUBCUTANEOUS SUSPENSION 100 UNIT/ML (*insulin nph human (isophane)*)	Non Preferred	PA
INSULINS: INSULIN R [OPEN CLASS]		
HUMULIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLIN R FLEXPEN INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin regular human*)	Non Preferred	PA
NOVOLIN R FLEXPEN RELION INJECTION SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin regular human*)	Non Preferred	PA
NOVOLIN R INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	Non Preferred	PA
NOVOLIN R RELION INJECTION SOLUTION 100 UNIT/ML (*insulin regular human*)	Non Preferred	PA
INSULINS: LONG-ACTING [OPEN CLASS]		
insulin glargine solostar subcutaneous solution pen-injector 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin glargine subcutaneous solution 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin glargine-yfgn subcutaneous solution 100 unit/ml	Preferred	
insulin glargine-yfgn subcutaneous solution pen-injector 100 unit/ml	Preferred	
BASAGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	Preferred	90-day fill allowed after two 1-month fills
LANTUS SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	Preferred	90-day fill allowed after two 1-month fills
LANTUS SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine*)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
LEVEMIR FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin detemir*)	Preferred	90-day fill allowed after two 1-month fills
LEVEMIR SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin detemir*)	Preferred	90-day fill allowed after two 1-month fills
REZVOGLAR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine-aglr*)	Preferred	
insulin degludec flextouch subcutaneous solution pen-injector 100 unit/ml, 200 unit/ml	Non Preferred	PA
insulin degludec subcutaneous solution 100 unit/ml	Non Preferred	PA
insulin glargine max solostar subcutaneous solution pen-injector 300 unit/ml	Non Preferred	PA
insulin glargine solostar subcutaneous solution pen-injector 300 unit/ml	Non Preferred	PA
BASAGLAR TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine*)	Non Preferred	PA
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin glargine-yfgn*)	Non Preferred	PA
SEMGLEE (YFGN) SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glargine-yfgn*)	Non Preferred	PA
TOUJEO MAX SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*)	Non Preferred	PA
TOUJEO SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 300 UNIT/ML (*insulin glargine*)	Non Preferred	PA
TRESIBA FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin degludec*)	Non Preferred	PA
TRESIBA SUBCUTANEOUS SOLUTION 100 UNIT/ML (*insulin degludec*)	Non Preferred	PA
INSULINS: RAPID-ACTING [OPEN CLASS]		
insulin aspart flexpen subcutaneous solution pen-injector 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin aspart injection solution 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin aspart penfill subcutaneous solution cartridge 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin lispro injection solution 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
insulin lispro junior kwikpen subcutaneous solution pen-injector 100 unit/ml	Preferred	90-day fill allowed after two 1-month fills
ADMELOG INJECTION SOLUTION 100 UNIT/ML (*insulin lispro*)	Preferred	90-day fill allowed after two 1-month fills
ADMELOG SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
HUMALOG INJECTION SOLUTION 100 UNIT/ML (*insulin lispro*)	Preferred	90-day fill allowed after two 1-month fills
HUMALOG JUNIOR KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	Preferred	90-day fill allowed after two 1-month fills
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	Preferred	90-day fill allowed after two 1-month fills
HUMALOG SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin lispro*)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN R U-500 (CONCENTRATED) SUBCUTANEOUS SOLUTION 500 UNIT/ML (*insulin regular human*)	Preferred	90-day fill allowed after two 1-month fills
HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 500 UNIT/ML (*insulin regular human*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG FLEXPEN RELION SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG FLEXPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG INJECTION SOLUTION 100 UNIT/ML (*insulin aspart*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart*)	Preferred	90-day fill allowed after two 1-month fills
NOVOLOG RELION INJECTION SOLUTION 100 UNIT/ML (*insulin aspart*)	Preferred	90-day fill allowed after two 1-month fills
AFREZZA INHALATION POWDER 12 UNIT, 4 UNIT, 60X4 &60X8 & 60X12 UNIT, 8 UNIT, 90 X 4 UNIT & 90X8 UNIT, 90 X 8 UNIT & 90X12 UNIT (*insulin regular human*)	Non Preferred	PA
APIDRA INJECTION SOLUTION 100 UNIT/ML (*insulin glulisine*)	Non Preferred	PA
APIDRA SOLOSTAR SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin glulisine*)	Non Preferred	PA
FIASP FLEXTOUCH SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	Non Preferred	PA
FIASP INJECTION SOLUTION 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	Non Preferred	PA
FIASP PENFILL SUBCUTANEOUS SOLUTION CARTRIDGE 100 UNIT/ML (*insulin aspart (w/niacinamide)*)	Non Preferred	PA
HUMALOG KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 UNIT/ML (*insulin lispro*)	Non Preferred	PA
HUMALOG TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro*)	Non Preferred	PA
LYUMJEV INJECTION SOLUTION 100 UNIT/ML (*insulin lispro-aabc*)	Non Preferred	PA
LYUMJEV KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML, 200 UNIT/ML (*insulin lispro-aabc*)	Non Preferred	PA
LYUMJEV TEMPO PEN SUBCUTANEOUS SOLUTION PEN-INJECTOR 100 UNIT/ML (*insulin lispro-aabc*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
INTRANASAL ANTIHISTAMINES [OPEN CLASS]		
azelastine hcl nasal solution 0.1 %, 137 mcg/spray	Preferred	
azelastine hcl nasal solution 0.15 %	Non Preferred	PA
olopatadine hcl nasal solution 0.6 %	Non Preferred	PA
PATANASE NASAL SOLUTION 0.6 % (*olopatadine hcl*)	Non Preferred	PA
RYALTRIS NASAL SUSPENSION 665-25 MCG/ACT (*olopatadine-mometasone*)	Non Preferred	PA; AGE (Min 18 Years)
LEUKOTRIENE RECEPTOR ANTAGONISTS [OPEN CLASS]		
montelukast sodium oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
montelukast sodium oral tablet chewable 4 mg	Preferred	AGE (Max 5 Years); 90-day fill allowed after two 1-month fills
montelukast sodium oral tablet chewable 5 mg	Preferred	AGE (Max 14 Years); 90-day fill allowed after two 1-month fills
montelukast sodium oral packet 4 mg	Non Preferred	PA; AGE (Max 5 Years)
zafirlukast oral tablet 10 mg, 20 mg	Non Preferred	PA
zileuton er oral tablet extended release 12 hour 600 mg	Non Preferred	PA
ACCOLATE ORAL TABLET 10 MG, 20 MG (*zafirlukast*)	Non Preferred	PA
SINGULAIR ORAL PACKET 4 MG (*montelukast sodium*)	Non Preferred	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET 10 MG (*montelukast sodium*)	Non Preferred	PA
SINGULAIR ORAL TABLET CHEWABLE 4 MG (*montelukast sodium*)	Non Preferred	PA; AGE (Max 5 Years)
SINGULAIR ORAL TABLET CHEWABLE 5 MG (*montelukast sodium*)	Non Preferred	PA; AGE (Max 14 Years)
ZYFLO ORAL TABLET 600 MG (*zileuton*)	Non Preferred	PA
LIPOTROPICS: BILE ACID SEQUESTRANTS [OPEN CLASS]		
cholestyramine light oral packet 4 gm	Preferred	90-day fill allowed after two 1-month fills
cholestyramine light oral powder 4 gm/dose	Preferred	90-day fill allowed after two 1-month fills
cholestyramine oral packet 4 gm	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
cholestyramine oral powder 4 gm/dose	Preferred	90-day fill allowed after two 1-month fills
colestipol hcl oral tablet 1 gm	Preferred	90-day fill allowed after two 1-month fills
cholestyramine light (Prevalite Oral Packet 4 Gm)	Preferred	90-day fill allowed after two 1-month fills
cholestyramine light (Prevalite Oral Powder 4 Gm/Dose)	Preferred	90-day fill allowed after two 1-month fills
colesevelam hcl oral packet 3.75 gm	Non Preferred	PA
colesevelam hcl oral tablet 625 mg	Non Preferred	PA
colestipol hcl oral granules 5 gm	Non Preferred	PA
colestipol hcl oral packet 5 gm	Non Preferred	PA
COLESTID ORAL GRANULES 5 GM (*colestipol hcl*)	Non Preferred	PA
COLESTID ORAL PACKET 5 GM (*colestipol hcl*)	Non Preferred	PA
COLESTID ORAL TABLET 1 GM (*colestipol hcl*)	Non Preferred	PA
QUESTRAN LIGHT ORAL POWDER 4 GM/DOSE (*cholestyramine light*)	Non Preferred	PA
QUESTRAN ORAL PACKET 4 GM (*cholestyramine*)	Non Preferred	PA
QUESTRAN ORAL POWDER 4 GM/DOSE (*cholestyramine*)	Non Preferred	PA
WELCHOL ORAL PACKET 3.75 GM (*colesevelam hcl*)	Non Preferred	PA
WELCHOL ORAL TABLET 625 MG (*colesevelam hcl*)	Non Preferred	PA
LIPOTROPICS: CHOLESTEROL ABSORPTION INHIBITORS (CAI) AND/OR ADENOSINE TRIPHOSPHATE CITRATE LYASE (ACL) INHIBITORS [OPEN CLASS]		
ezetimibe oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
NEXLETOL ORAL TABLET 180 MG (*bempedoic acid*)	Non Preferred	PA; AGE (Min 18 Years)
NEXLIZET ORAL TABLET 180-10 MG (*bempedoic acid-ezetimibe*)	Non Preferred	PA; AGE (Min 18 Years)
ZETIA ORAL TABLET 10 MG (*ezetimibe*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
LIPOTROPICS: FIBRIC ACID DERIVATIVES [OPEN CLASS]		
fenofibrate oral tablet 145 mg, 48 mg	Preferred	90-day fill allowed after two 1-month fills
gemfibrozil oral tablet 600 mg	Preferred	90-day fill allowed after two 1-month fills
fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg, 90 mg	Non Preferred	PA
fenofibrate oral capsule 134 mg, 150 mg, 200 mg, 50 mg, 67 mg	Non Preferred	PA
fenofibrate oral tablet 120 mg, 160 mg, 40 mg, 54 mg	Non Preferred	PA
fenofibric acid oral capsule delayed release 135 mg, 45 mg	Non Preferred	PA
fenofibric acid oral tablet 105 mg, 35 mg	Non Preferred	PA
FENOGLIDE ORAL TABLET 120 MG, 40 MG (*fenofibrate*)	Non Preferred	PA
FIBRICOR ORAL TABLET 105 MG, 35 MG (*fenofibric acid*)	Non Preferred	PA
LIPOFEN ORAL CAPSULE 150 MG, 50 MG (*fenofibrate*)	Non Preferred	PA
LOPID ORAL TABLET 600 MG (*gemfibrozil*)	Non Preferred	PA
TRICOR ORAL TABLET 145 MG, 48 MG (*fenofibrate*)	Non Preferred	PA
TRILIPIX ORAL CAPSULE DELAYED RELEASE 135 MG, 45 MG (*choline fenofibrate*)	Non Preferred	PA
LIPOTROPICS: JUXTAPID [OPEN CLASS]		
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG (*lomitapide mesylate*)	Non Preferred	SP; PA
LIPOTROPICS: NIACIN DERIVATIVES [OPEN CLASS]		
niacin er (antihyperlipidemic) oral tablet extended release 1000 mg, 500 mg, 750 mg	Preferred	
LIPOTROPICS: OMEGA 3 FATTY ACID AGENTS [OPEN CLASS]		
omega-3-acid ethyl esters oral capsule 1 gm	Preferred	
VASCEPA ORAL CAPSULE 0.5 GM, 1 GM (*icosapent ethyl*)	Preferred	PA; AGE (Min 18 Years)
icosapent ethyl oral capsule 0.5 gm, 1 gm	Non Preferred	PA; AGE (Min 18 Years)
LOVAZA ORAL CAPSULE 1 GM (*omega-3-acid ethyl esters*)	Non Preferred	PA
LIPOTROPICS: PCSK9 [OPEN CLASS]		
LEQVIO SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 284 MG/1.5ML (*inclisiran sodium*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, 75 MG/ML (*alirocumab*)	Non Preferred	PA
REPATHA PUSHTRONEX SYSTEM SUBCUTANEOUS SOLUTION CARTRIDGE 420 MG/3.5ML (*evolocumab*)	Non Preferred	PA
REPATHA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 140 MG/ML (*evolocumab*)	Non Preferred	PA
REPATHA SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML (*evolocumab*)	Non Preferred	PA
LIPOTROPICS: STATINS [OPEN CLASS]		
atorvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
lovastatin oral tablet 10 mg, 20 mg, 40 mg	Preferred	90-day fill allowed after two 1-month fills
pravastatin sodium oral tablet 10 mg, 20 mg, 40 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
rosuvastatin calcium oral tablet 10 mg, 20 mg, 40 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
amlodipine-atorvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg, 2.5-10 mg, 2.5-20 mg, 2.5-40 mg, 5-10 mg, 5-20 mg, 5-40 mg, 5-80 mg	Non Preferred	PA
ezetimibe-simvastatin oral tablet 10-10 mg, 10-20 mg, 10-40 mg, 10-80 mg	Non Preferred	PA
flolipid oral suspension 40 mg/5ml	Non Preferred	PA
fluvastatin sodium er oral tablet extended release 24 hour 80 mg	Non Preferred	PA
fluvastatin sodium oral capsule 20 mg, 40 mg	Non Preferred	PA
pitavastatin calcium oral tablet 1 mg, 2 mg, 4 mg	Non Preferred	PA
ALTOPREV ORAL TABLET EXTENDED RELEASE 24 HOUR 20 MG, 40 MG, 60 MG (*lovastatin*)	Non Preferred	PA
ATORVALIQ ORAL SUSPENSION 20 MG/5ML (*atorvastatin calcium*)	Non Preferred	PA
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG (*amlodipine-atorvastatin*)	Non Preferred	PA
EZALLOR SPRINKLE ORAL CAPSULE SPRINKLE 10 MG, 20 MG, 40 MG, 5 MG (*rosuvastatin calcium*)	Non Preferred	PA
LESCOL XL ORAL TABLET EXTENDED RELEASE 24 HOUR 80 MG (*fluvastatin sodium*)	Non Preferred	PA
LIPITOR ORAL TABLET 10 MG, 20 MG, 40 MG, 80 MG (*atorvastatin calcium*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
LIVALO ORAL TABLET 1 MG, 2 MG, 4 MG (*pitavastatin calcium*)	Non Preferred	PA
VYTORIN ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG (*ezetimibe-simvastatin*)	Non Preferred	PA
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG (*simvastatin*)	Non Preferred	PA
ZYPITAMAG ORAL TABLET 2 MG, 4 MG (*pitavastatin magnesium*)	Non Preferred	PA
MACROLIDES: ORAL [OPEN CLASS]		
azithromycin oral packet 1 gm	Preferred	
azithromycin oral suspension reconstituted 100 mg/5ml, 200 mg/5ml	Preferred	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	Preferred	
clarithromycin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Preferred	
clarithromycin oral tablet 250 mg, 500 mg	Preferred	
erythromycin base oral tablet delayed release 250 mg, 333 mg, 500 mg	Preferred	
erythromycin ethylsuccinate oral suspension reconstituted 200 mg/5ml	Preferred	
erythromycin oral tablet delayed release 250 mg, 333 mg, 500 mg	Preferred	
clarithromycin er oral tablet extended release 24 hour 500 mg	Non Preferred	PA
erythromycin base oral capsule delayed release particles 250 mg	Non Preferred	PA
erythromycin base oral tablet 250 mg, 500 mg	Non Preferred	PA
erythromycin ethylsuccinate oral suspension reconstituted 400 mg/5ml	Non Preferred	PA
erythromycin ethylsuccinate oral tablet 400 mg	Non Preferred	PA
E.E.S. 400 ORAL TABLET 400 MG (*erythromycin ethylsuccinate*)	Non Preferred	PA
E.E.S. GRANULES ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	Non Preferred	PA
ERYPED 200 ORAL SUSPENSION RECONSTITUTED 200 MG/5ML (*erythromycin ethylsuccinate*)	Non Preferred	PA
ERYPED 400 ORAL SUSPENSION RECONSTITUTED 400 MG/5ML (*erythromycin ethylsuccinate*)	Non Preferred	PA
erythromycin base (Ery-Tab Oral Tablet Delayed Release 250 Mg, 333 Mg, 500 Mg)	Non Preferred	PA
ERYTHROCIN STEARATE ORAL TABLET 250 MG (*erythromycin stearate*)	Non Preferred	PA
ZITHROMAX ORAL PACKET 1 GM (*azithromycin*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
ZITHROMAX ORAL SUSPENSION RECONSTITUTED 100 MG/5ML, 200 MG/5ML (*azithromycin*)	Non Preferred	PA
ZITHROMAX ORAL TABLET 250 MG, 500 MG (*azithromycin*)	Non Preferred	PA
ZITHROMAX TRI-PAK ORAL TABLET 500 MG (*azithromycin*)	Non Preferred	PA
ZITHROMAX Z-PAK ORAL TABLET 250 MG (*azithromycin*)	Non Preferred	PA
MOVEMENT DISORDERS [CLOSED CLASS]		
tetrabenazine oral tablet 12.5 mg, 25 mg	Preferred	SP; PA (Eligible for auto-PA approval); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG (*deutetrabenazine*)	Preferred	SP; PA (Eligible for auto-PA approval); QL (4 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG (*deutetrabenazine*)	Preferred	SP; PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 6 & 12 & 24 MG (*deutetrabenazine*)	Preferred	SP; PA (Eligible for auto-PA approval); QL (42 EA per 365 days); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE 40 MG, 80 MG (*valbenazine tosylate*)	Preferred	SP; PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE 60 MG (*valbenazine tosylate*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE SPRINKLE 40 MG, 60 MG, 80 MG (*valbenazine tosylate*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
INGREZZA ORAL CAPSULE THERAPY PACK 40 & 80 MG (*valbenazine tosylate*)	Preferred	SP; PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 18 Years)
XENAZINE ORAL TABLET 12.5 MG, 25 MG (*tetrabenazine*)	Preferred	SP; PA (Eligible for auto-PA approval); QL (4 EA per 1 day); AGE (Min 18 Years)
MULTIPLE SCLEROSIS [CLOSED CLASS]		
dalfampridine er oral tablet extended release 12 hour 10 mg	Preferred	SP; PA
dimethyl fumarate oral capsule delayed release 120 mg, 240 mg	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
dimethyl fumarate starter pack oral capsule delayed release therapy pack 120 & 240 mg	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
fingolimod hcl oral capsule 0.5 mg	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 10 Years)

Drug Name	Formulary Status	Requirements/Limits
teriflunomide oral tablet 14 mg, 7 mg	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT 30 MCG/0.5ML (*interferon beta-1a*)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT 30 MCG/0.5ML (*interferon beta-1a*)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
BETASERON SUBCUTANEOUS KIT 0.3 MG (*interferon beta-1b*)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML (*glatiramer acetate*)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
KESIMPTA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 20 MG/0.4ML (*ofatumumab*)	Preferred	SP; PA (Eligible for auto-PA approval); AGE (Min 18 Years)
glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml	Non Preferred	SP; PA; AGE (Min 18 Years)
AMPYRA ORAL TABLET EXTENDED RELEASE 12 HOUR 10 MG (*dalfampridine*)	Non Preferred	SP; PA
AUBAGIO ORAL TABLET 14 MG, 7 MG (*teriflunomide*)	Non Preferred	SP; PA; AGE (Min 18 Years)
BAFIERTAM ORAL CAPSULE DELAYED RELEASE 95 MG (*monomethyl fumarate*)	Non Preferred	SP; PA
BRIUMVI INTRAVENOUS SOLUTION 150 MG/6ML (*ublituximab-xiiy*)	Non Preferred	SP; PA; AGE (Min 18 Years)
COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/ML (*glatiramer acetate*)	Non Preferred	SP; PA; AGE (Min 18 Years)
GILENYA ORAL CAPSULE 0.25 MG, 0.5 MG (*fingolimod hcl*)	Non Preferred	SP; PA; AGE (Min 10 Years)
glatiramer acetate (Glatopa Subcutaneous Solution Prefilled Syringe 20 Mg/Ml, 40 Mg/Ml)	Non Preferred	SP; PA; AGE (Min 18 Years)
LEMTRADA INTRAVENOUS SOLUTION 12 MG/1.2ML (*alemtuzumab*)	Non Preferred	SP; PA
MAVENCLAD (10 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA
MAVENCLAD (4 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA
MAVENCLAD (5 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA
MAVENCLAD (6 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA
MAVENCLAD (7 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA

Drug Name	Formulary Status	Requirements/Limits
MAVENCLAD (8 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA
MAVENCLAD (9 TABS) ORAL TABLET THERAPY PACK 10 MG (*cladribine*)	Non Preferred	SP; PA
MAYZENT ORAL TABLET 0.25 MG, 2 MG (*siponimod fumarate*)	Non Preferred	SP; PA
MAYZENT ORAL TABLET 1 MG (*siponimod fumarate*)	Non Preferred	PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 12 X 0.25 MG (*siponimod fumarate*)	Non Preferred	SP; PA
MAYZENT STARTER PACK ORAL TABLET THERAPY PACK 7 X 0.25 MG (*siponimod fumarate*)	Non Preferred	PA
OCREVUS INTRAVENOUS SOLUTION 300 MG/10ML (*ocrelizumab*)	Non Preferred	SP; PA; AGE (Min 18 Years)
OCREVUS ZUNOVO SUBCUTANEOUS SOLUTION 920-23000 MG-UT/23ML (*ocrelizumab-hyaluronidase-ocsq*)	Non Preferred	PA; AGE (Min 18 Years)
PLEGRIDY INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	Non Preferred	SP; PA
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PEN-INJECTOR 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	Non Preferred	SP; PA
PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 63 & 94 MCG/0.5ML (*peginterferon beta-1a*)	Non Preferred	SP; PA
PLEGRIDY SUBCUTANEOUS SOLUTION PEN-INJECTOR 125 MCG/0.5ML (*peginterferon beta-1a*)	Non Preferred	SP; PA
PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 125 MCG/0.5ML (*peginterferon beta-1a*)	Non Preferred	SP; PA
PONVORY ORAL TABLET 20 MG (*ponesimod*)	Non Preferred	SP; PA
PONVORY STARTER PACK ORAL TABLET THERAPY PACK 2-3-4-5-6-7-8-9 & 10 MG (*ponesimod*)	Non Preferred	SP; PA
REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	Non Preferred	SP; PA
REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR 6X8.8 & 6X22 MCG (*interferon beta-1a*)	Non Preferred	SP; PA
REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 22 MCG/0.5ML, 44 MCG/0.5ML (*interferon beta-1a*)	Non Preferred	SP; PA
REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 6X8.8 & 6X22 MCG (*interferon beta-1a*)	Non Preferred	SP; PA
TASCENSO ODT ORAL TABLET DISPERSIBLE 0.25 MG, 0.5 MG (*fingolimod lauryl sulfate*)	Non Preferred	SP; PA; AGE (Min 10 Years and Max 17 Years)
TECFIDERA ORAL CAPSULE DELAYED RELEASE 120 MG, 240 MG (*dimethyl fumarate*)	Non Preferred	SP; PA; AGE (Min 18 Years)
TECFIDERA ORAL CAPSULE DELAYED RELEASE THERAPY PACK 120 & 240 MG (*dimethyl fumarate*)	Non Preferred	SP; PA; AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
TYSABRI INTRAVENOUS CONCENTRATE 300 MG/15ML (*natalizumab*)	Non Preferred	SP; PA; AGE (Min 18 Years)
VUMERITY ORAL CAPSULE DELAYED RELEASE 231 MG (*diroximel fumarate*)	Non Preferred	SP; PA
ZEPOSIA 7-DAY STARTER PACK ORAL CAPSULE THERAPY PACK 4 X 0.23MG & 3 X 0.46MG (*ozanimod hcl*)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZEPOSIA ORAL CAPSULE 0.92 MG (*ozanimod hcl*)	Non Preferred	SP; PA; AGE (Min 18 Years)
ZEPOSIA STARTER KIT ORAL CAPSULE THERAPY PACK 0.23MG &0.46MG 0.92MG(21) (*ozanimod hcl*)	Non Preferred	SP; PA; AGE (Min 18 Years)
NASAL STEROIDS [OPEN CLASS]		
allergy relief nasal suspension 50 mcg/act	Preferred	
fluticasone propionate suspension 50 mcg/act nasal (otc)	Preferred	
fluticasone propionate suspension 50 mcg/act nasal (rx)	Preferred	
ft 24 hour nasal allergy nasal aerosol 55 mcg/act	Preferred	
ft allergy relief 24 hr nasal suspension 50 mcg/act	Preferred	
gnp 24 hour nasal allergy nasal aerosol 55 mcg/act	Preferred	
gnp fluticasone propionate nasal suspension 50 mcg/act	Preferred	
goodsense 24-hr allergy nasal nasal suspension 50 mcg/act	Preferred	
goodsense nasal allergy spray nasal aerosol 55 mcg/act	Preferred	
hm 24 hour nasal allergy nasal aerosol 55 mcg/act	Preferred	
hm allergy relief nasal suspension 50 mcg/act	Preferred	
ipratropium bromide nasal solution 0.03 %, 0.06 %	Preferred	
nasal allergy 24 hour nasal aerosol 55 mcg/act	Preferred	
sm allergy relief nasal suspension 50 mcg/act	Preferred	
triamcinolone acetonide nasal aerosol 55 mcg/act	Preferred	
DYMISTA NASAL SUSPENSION 137-50 MCG/ACT (*azelastine-fluticasone*)	Preferred	AGE (Min 6 Years)
allergy nasal spray nasal suspension 50 mcg/act	Non Preferred	PA
azelastine-fluticasone nasal suspension 137-50 mcg/act	Non Preferred	PA; AGE (Min 6 Years)
budesonide nasal suspension 32 mcg/act	Non Preferred	PA
flunisolide nasal solution 25 mcg/act (0.025%)	Non Preferred	PA
gnp budesonide nasal spray nasal suspension 32 mcg/act	Non Preferred	PA
mometasone furoate suspension 50 mcg/act nasal (otc)	Non Preferred	PA
mometasone furoate suspension 50 mcg/act nasal (rx)	Non Preferred	PA
BECONASE AQ NASAL SUSPENSION 42 MCG/SPRAY (*beclomethasone diprop monohyd*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
NASONEX 24HR NASAL SUSPENSION 50 MCG/ACT (*mometasone furoate*)	Non Preferred	PA
OMNARIS NASAL SUSPENSION 50 MCG/ACT (*ciclesonide*)	Non Preferred	PA
QNASL CHILDRENS NASAL AEROSOL SOLUTION 40 MCG/ACT (*beclomethasone diprop (nasal)*)	Non Preferred	PA
QNASL NASAL AEROSOL SOLUTION 80 MCG/ACT (*beclomethasone diprop (nasal)*)	Non Preferred	PA
XHANCE NASAL EXHALER SUSPENSION 93 MCG/ACT (*fluticasone propionate*)	Non Preferred	PA
ZETONNA NASAL AEROSOL SOLUTION 37 MCG/ACT (*ciclesonide*)	Non Preferred	PA
NEUROPATHIC PAIN [OPEN CLASS]		
arthritis pain relieving external cream 0.075 %	Preferred	
capsaicin external cream 0.025 %, 0.075 %, 0.1 %	Preferred	
capsaicin pain relief external cream 0.1 %	Preferred	
duloxetine hcl oral capsule delayed release particles 20 mg, 30 mg, 60 mg	Preferred	
gabapentin oral capsule 100 mg, 300 mg, 400 mg	Preferred	
gabapentin oral solution 250 mg/5ml, 300 mg/6ml	Preferred	
gabapentin oral tablet 600 mg, 800 mg	Preferred	
gnp capsaicin external liquid 0.15 %	Preferred	
lidocaine external patch 5 %	Preferred	QL (90 EA per 1 Fill)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 225 mg, 25 mg, 300 mg, 50 mg, 75 mg	Preferred	
lidocaine (Lidocan Patch 5 % External)	Preferred	QL (90 EA per 1 Fill)
lidocaine (Tridacaine Ii External Patch 5 %)	Preferred	QL (90 EA per 1 Fill)
lidocaine (Tridacaine Iii External Patch 5 %)	Preferred	QL (90 EA per 1 Fill)
duloxetine hcl oral capsule delayed release particles 40 mg	Non Preferred	PA
gabapentin (once-daily) oral tablet 300 mg, 600 mg	Non Preferred	PA
pregabalin er oral tablet extended release 24 hour 165 mg, 330 mg, 82.5 mg	Non Preferred	PA
pregabalin oral solution 20 mg/ml	Non Preferred	PA
CYMBALTA ORAL CAPSULE DELAYED RELEASE PARTICLES 20 MG, 30 MG, 60 MG (*duloxetine hcl*)	Non Preferred	PA
DRIZALMA SPRINKLE ORAL CAPSULE DELAYED RELEASE SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG (*duloxetine hcl*)	Non Preferred	PA
GRALISE ORAL TABLET 300 MG, 450 MG, 600 MG, 750 MG, 900 MG (*gabapentin (once-daily)*)	Non Preferred	PA
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG, 600 MG (*gabapentin enacarbil*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
lidocaine (Lidocan Patch 5 % External)	Non Preferred	PA; QL (90 EA per 1 Fill)
LIDODERM EXTERNAL PATCH 5 % (*lidocaine*)	Non Preferred	PA; QL (90 EA per 1 Fill)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HOUR 165 MG, 330 MG, 82.5 MG (*pregabalin*)	Non Preferred	PA
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 225 MG, 25 MG, 300 MG, 50 MG, 75 MG (*pregabalin*)	Non Preferred	PA
LYRICA ORAL SOLUTION 20 MG/ML (*pregabalin*)	Non Preferred	PA
NEURONTIN ORAL CAPSULE 100 MG, 300 MG, 400 MG (*gabapentin*)	Non Preferred	PA
NEURONTIN ORAL SOLUTION 250 MG/5ML (*gabapentin*)	Non Preferred	PA
NEURONTIN ORAL TABLET 600 MG, 800 MG (*gabapentin*)	Non Preferred	PA
QUTENZA (2 PATCH) EXTERNAL KIT 8 % (*capsaicin-cleansing gel*)	Non Preferred	SP; PA
QUTENZA (4 PATCH) EXTERNAL KIT 8 % (*capsaicin-cleansing gel*)	Non Preferred	SP; PA
QUTENZA EXTERNAL KIT 8 % (*capsaicin-cleansing gel*)	Non Preferred	SP; PA
SAVELLA ORAL TABLET 100 MG, 12.5 MG, 25 MG, 50 MG (*milnacipran hcl*)	Non Preferred	PA
SAVELLA TITRATION PACK ORAL 12.5 & 25 & 50 MG (*milnacipran hcl*)	Non Preferred	PA
XYLIDERM EXTERNAL KIT 5 % (*lidocaine-adhesive sheets*)	Non Preferred	PA
ZTLIDO EXTERNAL PATCH 1.8 % (*lidocaine*)	Non Preferred	PA
NON-ERGOT DOPAMINE RECEPTOR AGONISTS [OPEN CLASS]		
pramipexole dihydrochloride oral tablet 0.125 mg, 0.25 mg, 0.5 mg, 0.75 mg, 1 mg, 1.5 mg	Preferred	90-day fill allowed after two 1-month fills
ropinirole hcl er oral tablet extended release 24 hour 2 mg, 8 mg	Preferred	
ropinirole hcl oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
pramipexole dihydrochloride er oral tablet extended release 24 hour 0.375 mg, 0.75 mg, 1.5 mg, 2.25 mg, 3 mg, 3.75 mg, 4.5 mg	Non Preferred	PA
ropinirole hcl er oral tablet extended release 24 hour 12 mg, 4 mg, 6 mg	Non Preferred	PA
MIRAPEX ER ORAL TABLET EXTENDED RELEASE 24 HOUR 0.375 MG, 0.75 MG, 2.25 MG, 3 MG, 3.75 MG, 4.5 MG (*pramipexole dihydrochloride*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
NEUPRO TRANSDERMAL PATCH 24 HOUR 1 MG/24HR, 2 MG/24HR, 3 MG/24HR, 4 MG/24HR, 6 MG/24HR, 8 MG/24HR (*rotigotine*)	Non Preferred	PA
NSAIDS [OPEN CLASS]		
all day pain relief oral tablet 220 mg	Preferred	90-day fill allowed after two 1-month fills
all day relief oral tablet 220 mg	Preferred	90-day fill allowed after two 1-month fills
arthritis pain reliever external gel 1 %	Preferred	90-day fill allowed after two 1-month fills
celecoxib oral capsule 100 mg, 200 mg	Preferred	
childrens ibuprofen oral suspension 100 mg/5ml	Preferred	
diclofenac epolamine external patch 1.3 %	Preferred	QL (30 EA per 1 Fill)
diclofenac sodium gel 1 % external (otc)	Preferred	90-day fill allowed after two 1-month fills
diclofenac sodium gel 1 % external (rx)	Preferred	90-day fill allowed after two 1-month fills
diclofenac sodium oral tablet delayed release 25 mg, 50 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
diflunisal oral tablet 500 mg	Preferred	
ec-naproxen oral tablet delayed release 375 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
etodolac oral capsule 200 mg, 300 mg	Preferred	
etodolac oral tablet 400 mg, 500 mg	Preferred	
flurbiprofen oral tablet 100 mg	Preferred	
ft all day pain relief oral tablet 220 mg	Preferred	90-day fill allowed after two 1-month fills
ft arthritis pain external gel 1 %	Preferred	90-day fill allowed after two 1-month fills
ft ibuprofen childrens oral suspension 100 mg/5ml	Preferred	
ft ibuprofen ib childrens oral tablet chewable 100 mg	Preferred	
ft ibuprofen minis oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
ft ibuprofen oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
ft ibuprofen oral tablet 200 mg	Preferred	90-day fill allowed after two 1-month fills
ft naproxen sodium oral capsule 220 mg	Preferred	90-day fill allowed after two 1-month fills
ft pain relief oral tablet 200 mg	Preferred	90-day fill allowed after two 1-month fills
gnp arthritis pain external gel 1 %	Preferred	90-day fill allowed after two 1-month fills
gnp childrens ibuprofen oral suspension 100 mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
gnp diclofenac sodium external gel 1 %	Preferred	90-day fill allowed after two 1-month fills
gnp ibuprofen childrens oral tablet chewable 100 mg	Preferred	
gnp ibuprofen infants oral suspension 50 mg/1.25ml	Preferred	90-day fill allowed after two 1-month fills
gnp ibuprofen oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
gnp ibuprofen oral tablet 200 mg	Preferred	90-day fill allowed after two 1-month fills
gnp naproxen sodium oral capsule 220 mg	Preferred	90-day fill allowed after two 1-month fills
gnp naproxen sodium oral tablet 220 mg	Preferred	90-day fill allowed after two 1-month fills
goodsense arthritis pain external gel 1 %	Preferred	90-day fill allowed after two 1-month fills
goodsense ibuprofen childrens oral suspension 100 mg/5ml	Preferred	
goodsense ibuprofen childrens oral tablet chewable 100 mg	Preferred	
goodsense ibuprofen infants oral suspension 50 mg/1.25ml	Preferred	90-day fill allowed after two 1-month fills
goodsense ibuprofen oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
goodsense ibuprofen oral tablet 200 mg	Preferred	90-day fill allowed after two 1-month fills
goodsense naproxen sodium oral tablet 220 mg	Preferred	90-day fill allowed after two 1-month fills
hm ibuprofen childrens oral suspension 100 mg/5ml	Preferred	
ibuprofen childrens oral suspension 100 mg/5ml	Preferred	
ibuprofen infants oral suspension 50 mg/1.25ml	Preferred	90-day fill allowed after two 1-month fills
ibuprofen junior strength oral tablet chewable 100 mg	Preferred	
ibuprofen oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
ibuprofen oral suspension 100 mg/5ml	Preferred	
ibuprofen oral tablet 200 mg, 400 mg, 600 mg, 800 mg	Preferred	90-day fill allowed after two 1-month fills
indomethacin oral capsule 25 mg, 50 mg	Preferred	
infants ibuprofen oral suspension 50 mg/1.25ml	Preferred	90-day fill allowed after two 1-month fills
ketorolac tromethamine oral tablet 10 mg	Preferred	Max 5 days of therapy every 90 days; QL (4 EA per 1 day)
meloxicam oral tablet 15 mg, 7.5 mg	Preferred	90-day fill allowed after two 1-month fills
naproxen dr oral tablet delayed release 500 mg	Preferred	90-day fill allowed after two 1-month fills

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
PA - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **RX** - Prescription Drug **SP** - Specialty Drug

Drug Name	Formulary Status	Requirements/Limits
naproxen oral tablet 250 mg, 375 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
naproxen oral tablet delayed release 375 mg, 500 mg	Preferred	90-day fill allowed after two 1-month fills
naproxen sodium oral capsule 220 mg	Preferred	90-day fill allowed after two 1-month fills
naproxen sodium oral tablet 220 mg, 275 mg, 550 mg	Preferred	90-day fill allowed after two 1-month fills
sm arthritis pain external gel 1 %	Preferred	90-day fill allowed after two 1-month fills
sm childrens ibuprofen oral suspension 100 mg/5ml	Preferred	
sm ibuprofen ib childrens oral tablet chewable 100 mg	Preferred	
sm ibuprofen oral capsule 200 mg	Preferred	90-day fill allowed after two 1-month fills
sm ibuprofen oral tablet 200 mg	Preferred	90-day fill allowed after two 1-month fills
sm infants ibuprofen oral suspension 50 mg/1.25ml	Preferred	90-day fill allowed after two 1-month fills
sm naproxen sodium oral tablet 220 mg	Preferred	90-day fill allowed after two 1-month fills
sulindac oral tablet 150 mg, 200 mg	Preferred	90-day fill allowed after two 1-month fills
ibuprofen (Ibu Oral Tablet 400 Mg, 600 Mg, 800 Mg)	Preferred	90-day fill allowed after two 1-month fills
celecoxib oral capsule 400 mg, 50 mg	Non Preferred	PA
diclofenac potassium oral capsule 25 mg	Non Preferred	PA
diclofenac potassium oral tablet 25 mg, 50 mg	Non Preferred	PA
diclofenac sodium er oral tablet extended release 24 hour 100 mg	Non Preferred	PA
diclofenac sodium external solution 1.5 %, 2 %	Non Preferred	PA
diclofenac-misoprostol oral tablet delayed release 50-0.2 mg, 75-0.2 mg	Non Preferred	PA
etodolac er oral tablet extended release 24 hour 400 mg, 500 mg, 600 mg	Non Preferred	PA
fenoprofen calcium oral capsule 400 mg	Non Preferred	PA
fenoprofen calcium oral tablet 600 mg	Non Preferred	PA
ibuprofen-famotidine oral tablet 800-26.6 mg	Non Preferred	PA
indomethacin er oral capsule extended release 75 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
indomethacin oral suspension 25 mg/5ml	Non Preferred	PA
indomethacin rectal suppository 50 mg	Non Preferred	PA
ketoprofen er oral capsule extended release 24 hour 200 mg	Non Preferred	PA
ketoprofen oral capsule 50 mg, 75 mg	Non Preferred	PA
ketorolac tromethamine nasal solution 15.75 mg/spray	Non Preferred	PA
meclofenamate sodium oral capsule 100 mg, 50 mg	Non Preferred	PA
mefenamic acid oral capsule 250 mg	Non Preferred	PA
meloxicam oral capsule 10 mg, 5 mg	Non Preferred	PA
nabumetone oral tablet 500 mg, 750 mg	Non Preferred	PA
naproxen oral suspension 125 mg/5ml	Non Preferred	PA
naproxen sodium er oral tablet extended release 24 hour 375 mg, 500 mg, 750 mg	Non Preferred	PA
naproxen-esomeprazole mg oral tablet delayed release 375-20 mg, 500-20 mg	Non Preferred	PA
oxaprozin oral tablet 600 mg	Non Preferred	PA
piroxicam oral capsule 10 mg, 20 mg	Non Preferred	PA
tolmetin sodium oral capsule 400 mg	Non Preferred	PA
tolmetin sodium oral tablet 600 mg	Non Preferred	PA
ARTHROTEC ORAL TABLET DELAYED RELEASE 50-0.2 MG, 75-0.2 MG (*diclofenac-misoprostol*)	Non Preferred	PA
CELEBREX ORAL CAPSULE 100 MG, 200 MG, 400 MG, 50 MG (*celecoxib*)	Non Preferred	PA
DAYPRO ORAL TABLET 600 MG (*oxaprozin*)	Non Preferred	PA
DUEXIS ORAL TABLET 800-26.6 MG (*ibuprofen-famotidine*)	Non Preferred	PA
FELDENE ORAL CAPSULE 10 MG, 20 MG (*piroxicam*)	Non Preferred	PA
FLECTOR EXTERNAL PATCH 1.3 % (*diclofenac epolamine*)	Non Preferred	PA; QL (30 EA per 1 Fill)
KIPROFEN ORAL CAPSULE 25 MG (*ketoprofen*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
LICART EXTERNAL PATCH 24 HOUR 1.3 % (*diclofenac epolamine*)	Non Preferred	PA; QL (30 EA per 1 Fill)
diclofenac potassium (Lofena Oral Tablet 25 Mg)	Non Preferred	PA
NALFON ORAL CAPSULE 400 MG (*fenoprofen calcium*)	Non Preferred	PA
NALFON ORAL TABLET 600 MG (*fenoprofen calcium*)	Non Preferred	PA
NAPRELAN ORAL TABLET EXTENDED RELEASE 24 HOUR 375 MG, 500 MG, 750 MG (*naproxen sodium*)	Non Preferred	PA
NAPROSYN ORAL SUSPENSION 125 MG/5ML (*naproxen*)	Non Preferred	PA
PENNSAID EXTERNAL SOLUTION 2 % (*diclofenac sodium*)	Non Preferred	PA
RELAFEN DS ORAL TABLET 1000 MG (*nabumetone*)	Non Preferred	PA
TOLECTIN 600 ORAL TABLET 600 MG (*tolmetin sodium*)	Non Preferred	PA
VIMOVO ORAL TABLET DELAYED RELEASE 375-20 MG, 500-20 MG (*naproxen-esomeprazole*)	Non Preferred	PA
OPHTHALMIC ANTIBIOTICS [OPEN CLASS]		
bacitracin ophthalmic ointment 500 unit/gm	Preferred	
bacitracin-polymyxin b ophthalmic ointment 500-10000 unit/gm	Preferred	
ciprofloxacin hcl ophthalmic solution 0.3 %	Preferred	
erythromycin ophthalmic ointment 5 mg/gm	Preferred	
gentamicin sulfate ophthalmic solution 0.3 %	Preferred	
moxifloxacin hcl ophthalmic solution 0.5 %	Preferred	
ofloxacin ophthalmic solution 0.3 %	Preferred	
polymyxin b-trimethoprim ophthalmic solution 10000-0.1 unit/ml-%	Preferred	
tobramycin ophthalmic solution 0.3 %	Preferred	
bacitracin-polymyxin b (Polycin Ophthalmic Ointment 500-10000 Unit/Gm)	Preferred	
gatifloxacin ophthalmic solution 0.5 %	Non Preferred	PA
moxifloxacin hcl (2x day) ophthalmic solution 0.5 %	Non Preferred	PA
neomycin-bacitracin zn-polymyx ophthalmic ointment 3.5-400-10000 , 5-400-10000	Non Preferred	PA
neomycin-polymyxin-gramicidin ophthalmic solution 1.75-10000-.025	Non Preferred	PA
sulfacetamide sodium ophthalmic ointment 10 %	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
sulfacetamide sodium ophthalmic solution 10 %	Non Preferred	PA
AZASITE OPHTHALMIC SOLUTION 1 % (*azithromycin*)	Non Preferred	PA
BESIVANCE OPHTHALMIC SUSPENSION 0.6 % (*besifloxacin hcl*)	Non Preferred	PA
CILOXAN OPHTHALMIC OINTMENT 0.3 % (*ciprofloxacin hcl*)	Non Preferred	PA
NATACYN OPHTHALMIC SUSPENSION 5 % (*natamycin*)	Non Preferred	PA
neomycin-bacitracin zn-polymyx (Neo-Polycin Ophthalmic Ointment 3.5-400-10000)	Non Preferred	PA
OCUFLOX OPHTHALMIC SOLUTION 0.3 % (*ofloxacin*)	Non Preferred	PA
TOBREX OPHTHALMIC OINTMENT 0.3 % (*tobramycin*)	Non Preferred	PA
VIGAMOX OPHTHALMIC SOLUTION 0.5 % (*moxifloxacin hcl*)	Non Preferred	PA
OPHTHALMIC ANTIBIOTICS: STEROID COMBINATIONS [OPEN CLASS]		
neomycin-polymyxin-dexameth ophthalmic ointment 3.5-10000-0.1	Preferred	
neomycin-polymyxin-dexameth ophthalmic suspension 3.5-10000-0.1	Preferred	
sulfacetamide-prednisolone ophthalmic solution 10-0.23 %	Preferred	
tobramycin-dexamethasone ophthalmic suspension 0.3-0.1 %	Preferred	
TOBRADEX OPHTHALMIC OINTMENT 0.3-0.1 % (*tobramycin-dexamethasone*)	Preferred	
TOBRADEX OPHTHALMIC SUSPENSION 0.3-0.1 % (*tobramycin-dexamethasone*)	Preferred	
bacitra-neomycin-polymyxin-hc ophthalmic ointment 1 %	Non Preferred	PA
neomycin-polymyxin-hc ophthalmic suspension 3.5-10000-1	Non Preferred	PA
MAXITROL OPHTHALMIC OINTMENT 3.5-10000-0.1 (*neomycin-polymyxin-dexameth*)	Non Preferred	PA
MAXITROL OPHTHALMIC SUSPENSION 0.1 % (*neomycin-polymyxin-dexameth*)	Non Preferred	PA
bacitracin-polymyx-neo-hc (Neo-Polycin Hc Ophthalmic Ointment 1 %)	Non Preferred	PA
TOBRADEX ST OPHTHALMIC SUSPENSION 0.3-0.05 % (*tobramycin-dexamethasone*)	Non Preferred	PA
ZYLET OPHTHALMIC SUSPENSION 0.5-0.3 % (*loteprednol-tobramycin*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
OPHTHALMICS: ALLERGIC CONJUNCTIVITIS [OPEN CLASS]		
azelastine hcl ophthalmic solution 0.05 %	Preferred	
cromolyn sodium ophthalmic solution 4 %	Preferred	
epinastine hcl ophthalmic solution 0.05 %	Preferred	
eye allergy itch relief ophthalmic solution 0.2 %	Preferred	
eye allergy itch/redness rel ophthalmic solution 0.1 %	Preferred	
eye itch relief ophthalmic solution 0.035 %	Preferred	
ft eye allergy itch & redness ophthalmic solution 0.1 %	Preferred	
ft eye allergy itch relief ophthalmic solution 0.2 %	Preferred	
gnp olopatadine hcl ophthalmic solution 0.1 %, 0.2 %	Preferred	
hm eye allergy itch relief ophthalmic solution 0.2 %	Preferred	
hm eye allergy itch/red relief ophthalmic solution 0.1 %	Preferred	
ketotifen fumarate ophthalmic solution 0.035 %	Preferred	
olopatadine hcl solution 0.1 % ophthalmic (otc)	Preferred	
olopatadine hcl solution 0.1 % ophthalmic (rx)	Preferred	
olopatadine hcl solution 0.2 % ophthalmic (otc)	Preferred	
olopatadine hcl solution 0.2 % ophthalmic (rx)	Preferred	
sm olopatadine hcl ophthalmic solution 0.2 %	Preferred	
ALAWAY CHILDRENS ALLERGY OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	Preferred	
ALAWAY OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	Preferred	
ZADITOR OPHTHALMIC SOLUTION 0.035 % (*ketotifen fumarate*)	Preferred	
bepotastine besilate ophthalmic solution 1.5 %	Non Preferred	PA
ALOCRIL OPHTHALMIC SOLUTION 2 % (*nedocromil sodium*)	Non Preferred	PA
ALOMIDE OPHTHALMIC SOLUTION 0.1 % (*lodoxamide tromethamine*)	Non Preferred	PA
BEPREVE OPHTHALMIC SOLUTION 1.5 % (*bepotastine besilate*)	Non Preferred	PA
LASTACAFT OPHTHALMIC SOLUTION 0.25 % (*alcaftadine*)	Non Preferred	PA
PATADAY OPHTHALMIC SOLUTION 0.1 %, 0.2 %, 0.7 % (*olopatadine hcl*)	Non Preferred	PA
ZERVIATE OPHTHALMIC SOLUTION 0.24 % (*cetirizine hcl*)	Non Preferred	PA
OPHTHALMICS: ANTI-INFLAMMATORY [OPEN CLASS]		
diclofenac sodium ophthalmic solution 0.1 %	Preferred	
fluorometholone ophthalmic suspension 0.1 %	Preferred	
flurbiprofen sodium ophthalmic solution 0.03 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
ketorolac tromethamine ophthalmic solution 0.4 %, 0.5 %	Preferred	
loteprednol etabonate ophthalmic gel 0.5 %	Preferred	
loteprednol etabonate ophthalmic suspension 0.5 %	Preferred	
prednisolone acetate ophthalmic suspension 1 %	Preferred	
DUREZOL OPHTHALMIC EMULSION 0.05 % (*difluprednate*)	Preferred	
bromfenac sodium (once-daily) ophthalmic solution 0.09 %	Non Preferred	PA
bromfenac sodium ophthalmic solution 0.07 %, 0.075 %	Non Preferred	PA
dexamethasone sodium phosphate ophthalmic solution 0.1 %	Non Preferred	PA
difluprednate ophthalmic emulsion 0.05 %	Non Preferred	PA
loteprednol etabonate ophthalmic suspension 0.2 %	Non Preferred	PA
prednisolone sodium phosphate ophthalmic solution 1 %	Non Preferred	PA
ACULAR LS OPHTHALMIC SOLUTION 0.4 % (*ketorolac tromethamine*)	Non Preferred	PA
ACULAR OPHTHALMIC SOLUTION 0.5 % (*ketorolac tromethamine*)	Non Preferred	PA
ACUVAIL OPHTHALMIC SOLUTION 0.45 % (*ketorolac tromethamine*)	Non Preferred	PA
ALREX OPHTHALMIC SUSPENSION 0.2 % (*loteprednol etabonate*)	Non Preferred	PA
BROMSITE OPHTHALMIC SOLUTION 0.075 % (*bromfenac sodium*)	Non Preferred	PA
FLAREX OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone acetate*)	Non Preferred	PA
FML FORTE OPHTHALMIC SUSPENSION 0.25 % (*fluorometholone*)	Non Preferred	PA
FML LIQUIFILM OPHTHALMIC SUSPENSION 0.1 % (*fluorometholone*)	Non Preferred	PA
ILEVRO OPHTHALMIC SUSPENSION 0.3 % (*nepafenac*)	Non Preferred	PA
INVELTYS OPHTHALMIC SUSPENSION 1 % (*loteprednol etabonate*)	Non Preferred	PA
LOTEMAX OPHTHALMIC GEL 0.5 % (*loteprednol etabonate*)	Non Preferred	PA
LOTEMAX OPHTHALMIC OINTMENT 0.5 % (*loteprednol etabonate*)	Non Preferred	PA
LOTEMAX OPHTHALMIC SUSPENSION 0.5 % (*loteprednol etabonate*)	Non Preferred	PA
LOTEMAX SM OPHTHALMIC GEL 0.38 % (*loteprednol etabonate*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
MAXIDEX OPHTHALMIC SUSPENSION 0.1 % (*dexamethasone*)	Non Preferred	PA
NEVANAC OPHTHALMIC SUSPENSION 0.1 % (*nepafenac*)	Non Preferred	PA
PRED FORTE OPHTHALMIC SUSPENSION 1 % (*prednisolone acetate*)	Non Preferred	PA
PRED MILD OPHTHALMIC SUSPENSION 0.12 % (*prednisolone acetate*)	Non Preferred	PA
PROLENSA OPHTHALMIC SOLUTION 0.07 % (*bromfenac sodium*)	Non Preferred	PA
OPHTHALMICS: GLAUCOMA AGENTS [OPEN CLASS]		
betaxolol hcl ophthalmic solution 0.5 %	Preferred	
brimonidine tartrate ophthalmic solution 0.15 %, 0.2 %	Preferred	
brinzolamide ophthalmic suspension 1 %	Preferred	
carteolol hcl ophthalmic solution 1 %	Preferred	
dorzolamide hcl ophthalmic solution 2 %	Preferred	
dorzolamide hcl-timolol mal ophthalmic solution 2-0.5 %	Preferred	
latanoprost ophthalmic solution 0.005 %	Preferred	
levobunolol hcl ophthalmic solution 0.5 %	Preferred	
pilocarpine hcl ophthalmic solution 1 %, 2 %, 4 %	Preferred	
timolol maleate (once-daily) solution 0.5 % ophthalmic	Preferred	
timolol maleate ophthalmic gel forming solution 0.25 %, 0.5 %	Preferred	
timolol maleate ophthalmic solution 0.25 %, 0.5 %	Preferred	
timolol maleate pf ophthalmic solution 0.5 %	Preferred	QL (2 EA per 1 day)
travoprost (bak free) ophthalmic solution 0.004 %	Preferred	
ALPHAGAN P OPHTHALMIC SOLUTION 0.1 %, 0.15 % (*brimonidine tartrate*)	Preferred	
AZOPT OPHTHALMIC SUSPENSION 1 % (*brinzolamide*)	Preferred	
COMBIGAN OPHTHALMIC SOLUTION 0.2-0.5 % (*brimonidine tartrate-timolol*)	Preferred	
RHOPRESSA OPHTHALMIC SOLUTION 0.02 % (*netarsudil dimesylate*)	Preferred	
ROCKLATAN OPHTHALMIC SOLUTION 0.02-0.005 % (*netarsudil-latanoprost*)	Preferred	
timolol maleate (Timolol Maleate Ocudose Ophthalmic Solution 0.5 %)	Preferred	QL (2 EA per 1 day)
TRAVATAN Z OPHTHALMIC SOLUTION 0.004 % (*travoprost*)	Preferred	
apraclonidine hcl ophthalmic solution 0.5 %	Non Preferred	PA
bimatoprost ophthalmic solution 0.03 %	Non Preferred	PA
brimonidine tartrate ophthalmic solution 0.1 %	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
brimonidine tartrate-timolol ophthalmic solution 0.2-0.5 %	Non Preferred	PA
dorzolamide hcl-timolol mal pf ophthalmic solution 2-0.5 %	Non Preferred	PA; QL (2 EA per 1 day)
tafluprost (pf) ophthalmic solution 0.0015 %	Non Preferred	PA; QL (1 EA per 1 day)
timolol maleate (once-daily) solution 0.5 % ophthalmic	Non Preferred	PA
timolol maleate pf ophthalmic solution 0.25 %	Non Preferred	PA; QL (2 EA per 1 day)
BETIMOL OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol hemihydrate*)	Non Preferred	PA
BETOPTIC-S OPHTHALMIC SUSPENSION 0.25 % (*betaxolol hcl*)	Non Preferred	PA
COSOPT OPHTHALMIC SOLUTION 2-0.5 % (*dorzolamide hcl-timolol mal*)	Non Preferred	PA
COSOPT PF OPHTHALMIC SOLUTION 2-0.5 % (*dorzolamide hcl-timolol mal*)	Non Preferred	PA; QL (2 EA per 1 day)
IOPIDINE OPHTHALMIC SOLUTION 1 % (*apraclonidine hcl*)	Non Preferred	PA
ISTALOL OPHTHALMIC SOLUTION 0.5 % (*timolol maleate*)	Non Preferred	PA
IYUZEH OPHTHALMIC SOLUTION 0.005 % (*latanoprost*)	Non Preferred	PA
LUMIGAN OPHTHALMIC SOLUTION 0.01 % (*bimatoprost*)	Non Preferred	PA
PHOSPHOLINE IODIDE OPHTHALMIC SOLUTION RECONSTITUTED 0.125 % (*echothiophate iodide*)	Non Preferred	PA
SIMBRINZA OPHTHALMIC SUSPENSION 1-0.2 % (*brinzolamide-brimonidine*)	Non Preferred	PA
TIMOPTIC OCUDOSE OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*)	Non Preferred	PA; QL (2 EA per 1 day)
TIMOPTIC OPHTHALMIC SOLUTION 0.25 %, 0.5 % (*timolol maleate*)	Non Preferred	PA
TIMOPTIC-XE OPHTHALMIC GEL FORMING SOLUTION 0.25 %, 0.5 % (*timolol maleate*)	Non Preferred	PA
VUITY OPHTHALMIC SOLUTION 1.25 % (*pilocarpine hcl*)	Non Preferred	PA
VYZULTA OPHTHALMIC SOLUTION 0.024 % (*latanoprostene bunod*)	Non Preferred	PA
XALATAN OPHTHALMIC SOLUTION 0.005 % (*latanoprost*)	Non Preferred	PA
XELPROS OPHTHALMIC EMULSION 0.005 % (*latanoprost*)	Non Preferred	PA
ZIOPTAN OPHTHALMIC SOLUTION 0.0015 % (*tafluprost*)	Non Preferred	PA; QL (1 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
OPHTHALMICS: IMMUNOMODULATORS [CLOSED CLASS]		
RESTASIS MULTIDOSE OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	Preferred	QL (5.5 ML per 30 days)
RESTASIS OPHTHALMIC EMULSION 0.05 % (*cyclosporine*)	Preferred	QL (60 EA per 30 days)
XIIDRA OPHTHALMIC SOLUTION 5 % (*lifitegrast*)	Preferred	QL (60 EA per 30 days)
cyclosporine ophthalmic emulsion 0.05 %	Non Preferred	PA; QL (60 EA per 30 days)
CEQUA OPHTHALMIC SOLUTION 0.09 % (*cyclosporine*)	Non Preferred	PA
EYSUVIS OPHTHALMIC SUSPENSION 0.25 % (*loteprednol etabonate*)	Non Preferred	PA
MIEBO OPHTHALMIC SOLUTION 1.338 GM/ML (*perfluorohexyloctane*)	Non Preferred	PA; QL (12 ML per 30 days); AGE (Min 18 Years)
TYRVAYA NASAL SOLUTION 0.03 MG/ACT (*varenicline tartrate*)	Non Preferred	PA
VERKAZIA OPHTHALMIC EMULSION 0.1 % (*cyclosporine*)	Non Preferred	PA
VEVYE OPHTHALMIC SOLUTION 0.1 % (*cyclosporine*)	Non Preferred	PA; QL (6 ML per 30 days)
OPIOID DEPENDENCY [CLOSED CLASS]		
buprenorphine hcl sublingual tablet sublingual 2 mg	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl sublingual tablet sublingual 8 mg	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual tablet sublingual 2-0.5 mg, 8-2 mg	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 1 day); AGE (Min 16 Years)
lifems naloxone injection prefilled syringe kit 2 mg/2ml	Preferred	
naloxone hcl injection solution 0.4 mg/ml, 4 mg/10ml	Preferred	
naloxone hcl injection solution cartridge 0.4 mg/ml	Preferred	
naloxone hcl injection solution prefilled syringe 0.4 mg/ml, 2 mg/2ml	Preferred	
naloxone hcl liquid 4 mg/0.1ml nasal (otc)	Preferred	
naloxone hcl liquid 4 mg/0.1ml nasal (rx)	Preferred	
naltrexone hcl oral tablet 50 mg	Preferred	
BRIXADI (WEEKLY) SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16 MG/0.32ML, 24 MG/0.48ML, 32 MG/0.64ML, 8 MG/0.16ML (*buprenorphine*)	Preferred	AGE (Min 18 Years)
BRIXADI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.36ML, 64 MG/0.18ML, 96 MG/0.27ML (*buprenorphine*)	Preferred	AGE (Min 18 Years)
KLOXXADO NASAL LIQUID 8 MG/0.1ML (*naloxone hcl*)	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (OTC) (*naloxone hcl*)	Preferred	
NARCAN LIQUID 4 MG/0.1ML NASAL (RX) (*naloxone hcl*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
OPVEE NASAL SOLUTION 2.7 MG/0.1ML (*nalmefene hcl*)	Preferred	QL (6 EA per 90 days); AGE (Min 12 Years); 90-day fill allowed after two 1-month fills
REXTOVY NASAL LIQUID 4 MG/0.25ML (*naloxone hcl*)	Preferred	
SUBLOCADE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.5ML, 300 MG/1.5ML (*buprenorphine*)	Preferred	SP
SUBOXONE SUBLINGUAL FILM 12-3 MG (*buprenorphine hcl-naloxone hcl*)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 1 day); AGE (Min 16 Years)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG, 8-2 MG (*buprenorphine hcl-naloxone hcl*)	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 1 day); AGE (Min 16 Years)
SUBOXONE SUBLINGUAL FILM 4-1 MG (*buprenorphine hcl-naloxone hcl*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 1 day); AGE (Min 16 Years)
VIVITROL INTRAMUSCULAR SUSPENSION RECONSTITUTED 380 MG (*naltrexone*)	Preferred	QL (1 EA per 28 days)
ZIMHI INJECTION SOLUTION PREFILLED SYRINGE 5 MG/0.5ML (*naloxone hcl*)	Preferred	
buprenorphine hcl-naloxone hcl sublingual film 12-3 mg	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 2-0.5 mg, 8-2 mg	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 16 Years)
buprenorphine hcl-naloxone hcl sublingual film 4-1 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 16 Years)
lofexidine hcl oral tablet 0.18 mg	Non Preferred	PA; AGE (Min 18 Years)
LUCEMYRA ORAL TABLET 0.18 MG (*lofexidine hcl*)	Non Preferred	PA; AGE (Min 18 Years)
ZUBSOLV SUBLINGUAL TABLET SUBLINGUAL 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG, 8.6-2.1 MG (*buprenorphine hcl-naloxone hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 16 Years)
OPIOIDS: LONG ACTING (LAO) [OPEN CLASS]		
buprenorphine transdermal patch weekly 10 mcg/hr, 5 mcg/hr, 7.5 mcg/hr	Preferred	PA; QL (0.29 EA per 1 day)
buprenorphine transdermal patch weekly 15 mcg/hr, 20 mcg/hr	Preferred	PA; QL (0.15 EA per 1 day)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	Preferred	PA; QL (0.334 EA per 1 day)
morphine sulfate er oral tablet extended release 100 mg, 200 mg	Preferred	PA; QL (1 EA per 1 day)
morphine sulfate er oral tablet extended release 15 mg	Preferred	PA; QL (4 EA per 1 day)
morphine sulfate er oral tablet extended release 30 mg	Preferred	PA; QL (3 EA per 1 day)
morphine sulfate er oral tablet extended release 60 mg	Preferred	PA; QL (2 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
BUTRANS TRANSDERMAL PATCH WEEKLY 10 MCG/HR, 5 MCG/HR, 7.5 MCG/HR (*buprenorphine*)	Preferred	PA; QL (0.29 EA per 1 day)
BUTRANS TRANSDERMAL PATCH WEEKLY 15 MCG/HR, 20 MCG/HR (*buprenorphine*)	Preferred	PA; QL (0.15 EA per 1 day)
fentanyl transdermal patch 72 hour 37.5 mcg/hr, 62.5 mcg/hr, 87.5 mcg/hr	Non Preferred	PA; QL (0.334 EA per 1 day)
hydrocodone bitartrate er oral capsule extended release 12 hour 10 mg	Non Preferred	PA; QL (6 EA per 1 day)
hydrocodone bitartrate er oral capsule extended release 12 hour 15 mg	Non Preferred	PA; QL (4 EA per 1 day)
hydrocodone bitartrate er oral capsule extended release 12 hour 20 mg	Non Preferred	PA; QL (3 EA per 1 day)
hydrocodone bitartrate er oral capsule extended release 12 hour 30 mg, 40 mg, 50 mg	Non Preferred	PA; QL (2 EA per 1 day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 100 mg, 120 mg, 40 mg, 60 mg, 80 mg	Non Preferred	PA; QL (1 EA per 1 day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 20 mg	Non Preferred	PA; QL (3 EA per 1 day)
hydrocodone bitartrate er oral tablet er 24 hour abuse-deterrent 30 mg	Non Preferred	PA; QL (2 EA per 1 day)
hydromorphone hcl er oral tablet extended release 24 hour 12 mg	Non Preferred	PA; QL (2 EA per 1 day)
hydromorphone hcl er oral tablet extended release 24 hour 16 mg, 32 mg	Non Preferred	PA; QL (1 EA per 1 day)
hydromorphone hcl er oral tablet extended release 24 hour 8 mg	Non Preferred	PA; QL (3 EA per 1 day)
methadone hcl oral concentrate 10 mg/ml	Non Preferred	PA; QL (4 EA per 1 day); AGE (Max 1 Years)
methadone hcl oral solution 10 mg/5ml	Non Preferred	PA; QL (15 ML per 1 day); AGE (Max 1 Years)
methadone hcl oral solution 5 mg/5ml	Non Preferred	PA; QL (40 ML per 1 day); AGE (Max 1 Years)
methadone hcl oral tablet 10 mg, 5 mg	Non Preferred	PA; QL (6 EA per 1 day); AGE (Max 1 Years)
methadone hcl oral tablet soluble 40 mg	Non Preferred	PA; QL (3 EA per 1 day); AGE (Max 1 Years)
morphine sulfate er beads oral capsule extended release 24 hour 120 mg, 90 mg	Non Preferred	PA; QL (1 EA per 1 day)
morphine sulfate er beads oral capsule extended release 24 hour 30 mg, 45 mg	Non Preferred	PA; QL (3 EA per 1 day)
morphine sulfate er beads oral capsule extended release 24 hour 60 mg, 75 mg	Non Preferred	PA; QL (2 EA per 1 day)
morphine sulfate er oral capsule extended release 24 hour 10 mg	Non Preferred	PA; QL (6 EA per 1 day)
morphine sulfate er oral capsule extended release 24 hour 100 mg, 80 mg	Non Preferred	PA; QL (1 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
morphine sulfate er oral capsule extended release 24 hour 20 mg	Non Preferred	PA; QL (4 EA per 1 day)
morphine sulfate er oral capsule extended release 24 hour 30 mg	Non Preferred	PA; QL (3 EA per 1 day)
morphine sulfate er oral capsule extended release 24 hour 50 mg, 60 mg	Non Preferred	PA; QL (2 EA per 1 day)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 10 mg	Non Preferred	PA; QL (6 EA per 1 day)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 20 mg	Non Preferred	PA; QL (4 EA per 1 day)
oxycodone hcl er oral tablet er 12 hour abuse-deterrent 40 mg, 80 mg	Non Preferred	PA; QL (2 EA per 1 day)
oxymorphone hcl er oral tablet extended release 12 hour 10 mg, 7.5 mg	Non Preferred	PA; QL (4 EA per 1 day)
oxymorphone hcl er oral tablet extended release 12 hour 15 mg	Non Preferred	PA; QL (3 EA per 1 day)
oxymorphone hcl er oral tablet extended release 12 hour 20 mg, 30 mg, 40 mg	Non Preferred	PA; QL (2 EA per 1 day)
oxymorphone hcl er oral tablet extended release 12 hour 5 mg	Non Preferred	PA; QL (6 EA per 1 day)
tramadol hcl (er biphasic) oral capsule extended release 24 hour 100 mg, 200 mg, 300 mg	Non Preferred	PA; AGE (Min 12 Years)
tramadol hcl (er biphasic) oral tablet extended release 24 hour 100 mg, 200 mg, 300 mg	Non Preferred	PA; AGE (Min 12 Years)
tramadol hcl er oral tablet extended release 24 hour 100 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 12 Years)
tramadol hcl er oral tablet extended release 24 hour 200 mg, 300 mg	Non Preferred	PA; QL (3 EA per 1 day); AGE (Min 12 Years)
BELBUCA BUCCAL FILM 150 MCG (*buprenorphine hcl*)	Non Preferred	PA; QL (4 EA per 1 day)
BELBUCA BUCCAL FILM 300 MCG, 600 MCG (*buprenorphine hcl*)	Non Preferred	PA; QL (3 EA per 1 day)
BELBUCA BUCCAL FILM 450 MCG, 750 MCG, 900 MCG (*buprenorphine hcl*)	Non Preferred	PA; QL (2 EA per 1 day)
BELBUCA BUCCAL FILM 75 MCG (*buprenorphine hcl*)	Non Preferred	PA; QL (6 EA per 1 day)
CONZIP ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 200 MG, 300 MG (*tramadol hcl*)	Non Preferred	PA; AGE (Min 12 Years)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 100 MG, 120 MG, 40 MG, 60 MG, 80 MG (*hydrocodone bitartrate*)	Non Preferred	PA; QL (1 EA per 1 day)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 20 MG (*hydrocodone bitartrate*)	Non Preferred	PA; QL (3 EA per 1 day)
HYSINGLA ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT 30 MG (*hydrocodone bitartrate*)	Non Preferred	PA; QL (2 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
methadone hcl (Methadone Hcl Intensol Oral Concentrate 10 Mg/Ml)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
METHADOSE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
methadone hcl (Methadose Oral Tablet Soluble 40 Mg)	Non Preferred	PA; QL (3 EA per 1 day); AGE (Max 1 Years)
METHADOSE SUGAR-FREE ORAL CONCENTRATE 10 MG/ML (*methadone hcl*)	Non Preferred	PA; QL (4 ML per 1 day); AGE (Max 1 Years)
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG (*morphine sulfate*)	Non Preferred	PA; QL (1 EA per 1 day)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG (*morphine sulfate*)	Non Preferred	PA; QL (4 EA per 1 day)
MS CONTIN ORAL TABLET EXTENDED RELEASE 30 MG (*morphine sulfate*)	Non Preferred	PA; QL (3 EA per 1 day)
MS CONTIN ORAL TABLET EXTENDED RELEASE 60 MG (*morphine sulfate*)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 100 MG (*tapentadol hcl*)	Non Preferred	PA; QL (3 EA per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 150 MG, 200 MG, 250 MG (*tapentadol hcl*)	Non Preferred	PA; QL (2 EA per 1 day)
NUCYNTA ER ORAL TABLET EXTENDED RELEASE 12 HOUR 50 MG (*tapentadol hcl*)	Non Preferred	PA; QL (4 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 10 MG (*oxycodone hcl*)	Non Preferred	PA; QL (6 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 15 MG (*oxycodone hcl*)	Non Preferred	PA; QL (5 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 20 MG (*oxycodone hcl*)	Non Preferred	PA; QL (4 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 30 MG (*oxycodone hcl*)	Non Preferred	PA; QL (3 EA per 1 day)
OXYCONTIN ORAL TABLET ER 12 HOUR ABUSE-DETERRENT 40 MG, 60 MG, 80 MG (*oxycodone hcl*)	Non Preferred	PA; QL (2 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 13.5 MG (*oxycodone*)	Non Preferred	PA; QL (5 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 18 MG (*oxycodone*)	Non Preferred	PA; QL (4 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 27 MG (*oxycodone*)	Non Preferred	PA; QL (3 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 36 MG (*oxycodone*)	Non Preferred	PA; QL (2 EA per 1 day)
XTAMPZA ER ORAL CAPSULE ER 12 HOUR ABUSE-DETERRENT 9 MG (*oxycodone*)	Non Preferred	PA; QL (6 EA per 1 day)
OPIOIDS: SHORT ACTING [OPEN CLASS]		
acetaminophen-codeine oral solution 120-12 mg/5ml	Preferred	QL (150 ML per 1 day); AGE (Min 12 Years)

Drug Name	Formulary Status	Requirements/Limits
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg, 300-60 mg	Preferred	QL (10 EA per 1 day); AGE (Min 12 Years)
hydrocodone-acetaminophen oral solution 10-325 mg/15ml	Preferred	QL (135 ML per 1 day)
hydrocodone-acetaminophen oral solution 2.5-108 mg/5ml, 5-217 mg/10ml, 7.5-325 mg/15ml	Preferred	QL (180 ML per 1 day)
hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg	Preferred	QL (9 EA per 1 day)
hydrocodone-acetaminophen oral tablet 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg	Preferred	QL (12 EA per 1 day)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg	Preferred	QL (5 EA per 1 day)
hydromorphone hcl oral tablet 2 mg	Preferred	QL (11.2 EA per 1 day)
hydromorphone hcl oral tablet 4 mg	Preferred	QL (5.6 EA per 1 day)
hydromorphone hcl oral tablet 8 mg	Preferred	QL (2.8 EA per 1 day)
morphine sulfate (concentrate) oral solution 100 mg/5ml, 20 mg/ml	Preferred	QL (4.5 ML per 1 day)
morphine sulfate oral solution 10 mg/5ml	Preferred	QL (45 ML per 1 day)
morphine sulfate oral solution 20 mg/5ml	Preferred	QL (22.5 ML per 1 day)
morphine sulfate oral tablet 15 mg	Preferred	QL (6 EA per 1 day)
morphine sulfate oral tablet 30 mg	Preferred	QL (3 EA per 1 day)
oxycodone hcl oral capsule 5 mg	Preferred	QL (12 EA per 1 day)
oxycodone hcl oral solution 5 mg/5ml	Preferred	QL (60 ML per 1 day)
oxycodone hcl oral tablet 10 mg	Preferred	QL (6 EA per 1 day)
oxycodone hcl oral tablet 15 mg	Preferred	QL (4 EA per 1 day)
oxycodone hcl oral tablet 20 mg	Preferred	QL (3 EA per 1 day)
oxycodone hcl oral tablet 30 mg	Preferred	QL (2 EA per 1 day)
oxycodone hcl oral tablet 5 mg	Preferred	QL (12 EA per 1 day)
oxycodone-acetaminophen oral solution 5-325 mg/5ml	Preferred	QL (60 ML per 1 day)
oxycodone-acetaminophen oral tablet 10-325 mg	Preferred	QL (6 EA per 1 day)
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg	Preferred	QL (12 EA per 1 day)
oxycodone-acetaminophen oral tablet 7.5-325 mg	Preferred	QL (8 EA per 1 day)
tramadol hcl oral tablet 50 mg	Preferred	QL (8 EA per 1 day); AGE (Min 12 Years)
tramadol-acetaminophen oral tablet 37.5-325 mg	Preferred	QL (8 EA per 1 day); AGE (Min 12 Years)
apap-caff-dihydrocodeine oral capsule 320.5-30-16 mg	Non Preferred	PA; AGE (Min 12 Years)
butalbital-apap-caff-cod oral capsule 50-300-40-30 mg, 50-325-40-30 mg	Non Preferred	PA; AGE (Min 12 Years)
butalbital-asa-caff-codeine oral capsule 50-325-40-30 mg	Non Preferred	PA; AGE (Min 12 Years)
butorphanol tartrate nasal solution 10 mg/ml	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
codeine sulfate oral tablet 15 mg	Non Preferred	PA; QL (24 EA per 1 day); AGE (Min 12 Years)
codeine sulfate oral tablet 30 mg	Non Preferred	PA; QL (12 EA per 1 day); AGE (Min 12 Years)
codeine sulfate oral tablet 60 mg	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 12 Years)
fentanyl citrate buccal lozenge on a handle 1200 mcg, 1600 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg	Non Preferred	PA
fentanyl citrate buccal tablet 200 mcg	Non Preferred	PA; QL (3.6 EA per 1 day)
fentanyl citrate buccal tablet 400 mcg	Non Preferred	PA; QL (1.8 EA per 1 day)
fentanyl citrate buccal tablet 600 mcg	Non Preferred	PA; QL (1.2 EA per 1 day)
fentanyl citrate buccal tablet 800 mcg	Non Preferred	PA; QL (0.9 EA per 1 day)
hydromorphone hcl oral liquid 1 mg/ml	Non Preferred	PA; QL (22.5 ML per 1 day)
hydromorphone hcl rectal suppository 3 mg	Non Preferred	PA; QL (4 EA per 1 day)
levorphanol tartrate oral tablet 2 mg	Non Preferred	PA; QL (4 EA per 1 day)
levorphanol tartrate oral tablet 3 mg	Non Preferred	PA; QL (2 EA per 1 day)
meperidine hcl oral solution 50 mg/5ml	Non Preferred	PA; QL (90 ML per 1 day)
meperidine hcl oral tablet 50 mg	Non Preferred	PA; QL (18 EA per 1 day)
morphine sulfate rectal suppository 10 mg	Non Preferred	PA; QL (9 EA per 1 day)
morphine sulfate rectal suppository 20 mg	Non Preferred	PA; QL (4.5 EA per 1 day)
morphine sulfate rectal suppository 30 mg	Non Preferred	PA; QL (3 EA per 1 day)
morphine sulfate rectal suppository 5 mg	Non Preferred	PA; QL (18 EA per 1 day)
nalocet oral tablet 2.5-300 mg	Non Preferred	PA; QL (12 EA per 1 day)
oxycodone hcl oral concentrate 100 mg/5ml	Non Preferred	PA; QL (3 ML per 1 day)
oxymorphone hcl oral tablet 10 mg	Non Preferred	PA; QL (3 EA per 1 day)
oxymorphone hcl oral tablet 5 mg	Non Preferred	PA; QL (6 EA per 1 day)
pentazocine-naloxone hcl oral tablet 50-0.5 mg	Non Preferred	PA; QL (4.9 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
tramadol hcl oral solution 5 mg/ml	Non Preferred	PA; QL (40 ML per 1 day); AGE (Min 12 Years)
tramadol hcl oral tablet 100 mg	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 12 Years)
tramadol hcl oral tablet 25 mg	Non Preferred	PA; QL (8 EA per 1 day)
ACTIQ BUCCAL LOZENGE ON A HANDLE 1600 MCG, 400 MCG, 800 MCG (*fentanyl citrate*)	Non Preferred	PA
butalbital-asa-caff-codeine (Ascomp-Codeine Oral Capsule 50-325-40-30 Mg)	Non Preferred	PA; AGE (Min 12 Years)
DILAUDID ORAL LIQUID 1 MG/ML (*hydromorphone hcl*)	Non Preferred	PA; QL (22.5 ML per 1 day)
DILAUDID ORAL TABLET 2 MG (*hydromorphone hcl*)	Non Preferred	PA; QL (11.2 EA per 1 day)
DILAUDID ORAL TABLET 4 MG (*hydromorphone hcl*)	Non Preferred	PA; QL (5.6 EA per 1 day)
DILAUDID ORAL TABLET 8 MG (*hydromorphone hcl*)	Non Preferred	PA; QL (2.8 EA per 1 day)
oxycodone-acetaminophen (Endocet Oral Tablet 10-325 Mg)	Non Preferred	PA; QL (6 EA per 1 day)
oxycodone-acetaminophen (Endocet Oral Tablet 5-325 Mg)	Non Preferred	PA; QL (12 EA per 1 day)
oxycodone-acetaminophen (Endocet Oral Tablet 7.5-325 Mg)	Non Preferred	PA; QL (8 EA per 1 day)
FENTORA BUCCAL TABLET 100 MCG (*fentanyl citrate*)	Non Preferred	PA; QL (7.2 EA per 1 day)
FENTORA BUCCAL TABLET 200 MCG (*fentanyl citrate*)	Non Preferred	PA; QL (3.6 EA per 1 day)
FENTORA BUCCAL TABLET 400 MCG (*fentanyl citrate*)	Non Preferred	PA; QL (1.8 EA per 1 day)
FENTORA BUCCAL TABLET 600 MCG (*fentanyl citrate*)	Non Preferred	PA; QL (1.2 EA per 1 day)
FENTORA BUCCAL TABLET 800 MCG (*fentanyl citrate*)	Non Preferred	PA; QL (0.9 EA per 1 day)
FIORICET/CODEINE ORAL CAPSULE 50-300-40-30 MG (*butalbital-apap-caff-cod*)	Non Preferred	PA; AGE (Min 12 Years)
NUCYNTA ORAL TABLET 100 MG (*tapentadol hcl*)	Non Preferred	PA; QL (2.25 EA per 1 day)
NUCYNTA ORAL TABLET 50 MG (*tapentadol hcl*)	Non Preferred	PA; QL (4.5 EA per 1 day)
NUCYNTA ORAL TABLET 75 MG (*tapentadol hcl*)	Non Preferred	PA; QL (3 EA per 1 day)
PERCOCET ORAL TABLET 10-325 MG (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (6 EA per 1 day)
PERCOCET ORAL TABLET 2.5-325 MG, 5-325 MG (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (12 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
PERCOCET ORAL TABLET 7.5-325 MG (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (8 EA per 1 day)
PROLATE ORAL SOLUTION 10-300 MG/5ML (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (60 ML per 1 day)
PROLATE ORAL TABLET 10-300 MG (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (6 EA per 1 day)
PROLATE ORAL TABLET 5-300 MG (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (12 EA per 1 day)
PROLATE ORAL TABLET 7.5-300 MG (*oxycodone-acetaminophen*)	Non Preferred	PA; QL (8 EA per 1 day)
QDOLO ORAL SOLUTION 5 MG/ML (*tramadol hcl*)	Non Preferred	PA; QL (40 ML per 1 day); AGE (Min 12 Years)
ROXICODONE ORAL TABLET 15 MG (*oxycodone hcl*)	Non Preferred	PA; QL (4 EA per 1 day)
ROXICODONE ORAL TABLET 30 MG (*oxycodone hcl*)	Non Preferred	PA; QL (2 EA per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 15 MG (*oxycodone hcl*)	Non Preferred	PA; QL (4 EA per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 30 MG (*oxycodone hcl*)	Non Preferred	PA; QL (2 EA per 1 day)
ROXYBOND ORAL TABLET ABUSE-DETERRENT 5 MG (*oxycodone hcl*)	Non Preferred	PA; QL (12 EA per 1 day)
SEGLENTIS ORAL TABLET 56-44 MG (*celecoxib-tramadol hcl*)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
OTIC [OPEN CLASS]		
ciprofloxacin-dexamethasone otic suspension 0.3-0.1 %	Preferred	
neomycin-polymyxin-hc otic solution 1 %, 3.5-10000-1	Preferred	
neomycin-polymyxin-hc otic suspension 3.5-10000-1	Preferred	
ofloxacin otic solution 0.3 %	Preferred	
CIPRODEX OTIC SUSPENSION 0.3-0.1 % (*ciprofloxacin-dexamethasone*)	Preferred	
ciprofloxacin hcl otic solution 0.2 %	Non Preferred	PA
ciprofloxacin-fluocinolone pf otic solution 0.3-0.025 %	Non Preferred	PA
CIPRO HC OTIC SUSPENSION 0.2-1 % (*ciprofloxacin-hydrocortisone*)	Non Preferred	PA
PANCREATIC ENZYMES [OPEN CLASS]		
CREON ORAL CAPSULE DELAYED RELEASE PARTICLES 12000-38000 UNIT, 24000-76000 UNIT, 3000-9500 UNIT, 36000-114000 UNIT, 6000-19000 UNIT (*pancrelipase (lip-prot-amyl)*)	Preferred	PA; 90-day fill allowed after two 1-month fills
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT (*pancrelipase (lip-prot-amyl)*)	Preferred	PA; 90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 60000-189600 UNIT (*pancrelipase (lip-prot-amyl)*)	Preferred	PA
PERTZYE ORAL CAPSULE DELAYED RELEASE PARTICLES 16000-57500 UNIT, 24000-86250 UNIT, 4000-14375 UNIT, 8000-28750 UNIT (*pancrelipase (lip-prot-amyl)*)	Non Preferred	PA
VIOKACE ORAL TABLET 10440-39150 UNIT, 20880-78300 UNIT (*pancrelipase (lip-prot-amyl)*)	Non Preferred	PA
PHOSPHATE BINDERS [OPEN CLASS]		
calcium acetate (phos binder) oral capsule 667 mg	Preferred	90-day fill allowed after two 1-month fills
calcium acetate (phos binder) tablet 667 mg oral (otc)	Preferred	
calcium acetate (phos binder) tablet 667 mg oral (rx)	Preferred	
calcium acetate oral tablet 667 mg	Preferred	
calcium acetate oral tablet 668 (169 ca) mg	Preferred	90-day fill allowed after two 1-month fills
lanthanum carbonate oral tablet chewable 500 mg, 750 mg	Preferred	
sevelamer carbonate oral tablet 800 mg	Preferred	90-day fill allowed after two 1-month fills
CALPHRON ORAL TABLET 667 MG (*calcium acetate (phos binder)*)	Preferred	
lanthanum carbonate oral tablet chewable 1000 mg	Non Preferred	PA
sevelamer carbonate oral packet 0.8 gm, 2.4 gm	Non Preferred	PA
sevelamer hcl oral tablet 400 mg, 800 mg	Non Preferred	PA
AURYXIA ORAL TABLET 1 GM 210 MG(FE) (*ferric citrate*)	Non Preferred	PA
FOSRENOL ORAL PACKET 1000 MG, 750 MG (*lanthanum carbonate*)	Non Preferred	PA
FOSRENOL ORAL TABLET CHEWABLE 1000 MG, 500 MG, 750 MG (*lanthanum carbonate*)	Non Preferred	PA
MAGNEBIND 400 ORAL TABLET 80-115 MG (*calcium carb-magnesium carb*)	Non Preferred	PA
PHOSLYRA ORAL SOLUTION 667 MG/5ML (*calcium acetate (phos binder)*)	Non Preferred	PA
RENVELA ORAL PACKET 0.8 GM, 2.4 GM (*sevelamer carbonate*)	Non Preferred	PA
RENVELA ORAL TABLET 800 MG (*sevelamer carbonate*)	Non Preferred	PA
VELPHORO ORAL TABLET CHEWABLE 500 MG (*sucroferric oxyhydroxide*)	Non Preferred	PA
XPHOZAH ORAL TABLET 20 MG, 30 MG (*tenapanor hcl (ckd)*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
PLATELET INHIBITORS [OPEN CLASS]		
clopidogrel bisulfate oral tablet 300 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
dipyridamole oral tablet 25 mg, 50 mg, 75 mg	Preferred	90-day fill allowed after two 1-month fills
prasugrel hcl oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
BRILINTA ORAL TABLET 60 MG, 90 MG (*ticagrelor*)	Preferred	90-day fill allowed after two 1-month fills
aspirin-dipyridamole er oral capsule extended release 12 hour 25-200 mg	Non Preferred	PA
EFFIENT ORAL TABLET 10 MG, 5 MG (*prasugrel hcl*)	Non Preferred	PA
PLAVIX ORAL TABLET 75 MG (*clopidogrel bisulfate*)	Non Preferred	PA
PROGESTATIONAL AGENTS [CLOSED CLASS]		
hydroxyprogesterone caproate intramuscular solution 1.25 gm/5ml	Preferred	
medroxyprogesterone acetate oral tablet 10 mg, 2.5 mg, 5 mg	Preferred	
norethindrone acetate oral tablet 5 mg	Preferred	
progesterone intramuscular oil 50 mg/ml	Preferred	
progesterone oral capsule 100 mg, 200 mg	Preferred	
norethindrone acetate (Gallifrey Oral Tablet 5 Mg)	Preferred	
AYGESTIN ORAL TABLET 5 MG (*norethindrone acetate*)	Non Preferred	PA
CRINONE VAGINAL GEL 4 %, 8 % (*progesterone*)	Non Preferred	PA
PROMETRIUM ORAL CAPSULE 100 MG, 200 MG (*progesterone*)	Non Preferred	PA
PROVERA ORAL TABLET 10 MG, 2.5 MG, 5 MG (*medroxyprogesterone acetate*)	Non Preferred	PA
PROGESTINS USED FOR CACHEXIA [OPEN CLASS]		
megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml	Preferred	
megestrol acetate oral tablet 20 mg, 40 mg	Preferred	
megestrol acetate oral suspension 625 mg/5ml	Non Preferred	PA
PROTON PUMP INHIBITORS [OPEN CLASS]		
acid reducer oral capsule delayed release 20.6 (20 base) mg	Preferred	QL (4 EA per 1 day)
esomeprazole magnesium capsule delayed release 20 mg oral (otc)	Preferred	QL (2 EA per 1 day)
esomeprazole magnesium capsule delayed release 20 mg oral (rx)	Preferred	QL (2 EA per 1 day)
esomeprazole magnesium oral capsule delayed release 40 mg	Preferred	QL (2 EA per 1 day)
ft acid reducer oral capsule delayed release 15 mg	Preferred	QL (2 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
gnp esomeprazole magnesium oral capsule delayed release 20 mg	Preferred	QL (2 EA per 1 day)
gnp lansoprazole oral capsule delayed release 15 mg	Preferred	QL (2 EA per 1 day)
gnp omeprazole oral capsule delayed release 20.6 (20 base) mg	Preferred	QL (4 EA per 1 day)
gnp omeprazole oral tablet delayed release dispersible 20 mg	Preferred	QL (4 EA per 1 day)
goodsense lansoprazole oral capsule delayed release 15 mg	Preferred	QL (2 EA per 1 day)
hm esomeprazole magnesium dr oral capsule delayed release 20 mg	Preferred	QL (2 EA per 1 day)
lansoprazole capsule delayed release 15 mg oral (otc)	Preferred	QL (2 EA per 1 day)
lansoprazole capsule delayed release 15 mg oral (rx)	Preferred	QL (2 EA per 1 day)
lansoprazole oral capsule delayed release 30 mg	Preferred	QL (2 EA per 1 day)
omeprazole magnesium oral capsule delayed release 20.6 (20 base) mg	Preferred	QL (4 EA per 1 day)
omeprazole magnesium oral tablet delayed release 20 mg	Preferred	QL (4 EA per 1 day)
omeprazole oral capsule delayed release 10 mg, 40 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
omeprazole oral capsule delayed release 20 mg	Preferred	QL (4 EA per 1 day); 90-day fill allowed after two 1-month fills
omeprazole oral tablet delayed release dispersible 20 mg	Preferred	QL (4 EA per 1 day)
pantoprazole sodium oral packet 40 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
pantoprazole sodium oral tablet delayed release 20 mg, 40 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
sm esomeprazole magnesium oral capsule delayed release 20 mg	Preferred	QL (2 EA per 1 day)
sm lansoprazole oral capsule delayed release 15 mg	Preferred	QL (2 EA per 1 day)
GOODSENSE ESOMEPRAZOLE ORAL CAPSULE DELAYED RELEASE 20 MG (*esomeprazole magnesium*)	Preferred	QL (2 EA per 1 day)
PROTONIX ORAL PACKET 40 MG (*pantoprazole sodium*)	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
dexlansoprazole oral capsule delayed release 30 mg, 60 mg	Non Preferred	PA
esomeprazole magnesium oral packet 10 mg, 20 mg, 40 mg	Non Preferred	PA; QL (2 EA per 1 day)
esomeprazole magnesium oral tablet delayed release 20 mg	Non Preferred	PA; QL (2 EA per 1 day)
ft omeprazole oral tablet delayed release 20 mg	Non Preferred	PA; QL (4 EA per 1 day)
gnp omeprazole oral tablet delayed release 20 mg	Non Preferred	PA; QL (4 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
goodsense lansoprazole oral tablet delayed release dispersible 15 mg	Non Preferred	PA; QL (2 EA per 1 day)
goodsense omep/sod bicarb oral capsule 20-1100 mg	Non Preferred	PA
lansoprazole oral tablet delayed release dispersible 15 mg, 30 mg	Non Preferred	PA; QL (2 EA per 1 day)
omeprazole oral tablet delayed release 20 mg	Non Preferred	PA; QL (4 EA per 1 day)
omeprazole-sodium bicarbonate oral capsule 20-1100 mg, 40-1100 mg	Non Preferred	PA
omeprazole-sodium bicarbonate oral packet 20-1680 mg, 40-1680 mg	Non Preferred	PA
rabeprazole sodium oral tablet delayed release 20 mg	Non Preferred	PA
sm omeprazole oral tablet delayed release 20 mg	Non Preferred	PA; QL (4 EA per 1 day)
ACIPHEX ORAL TABLET DELAYED RELEASE 20 MG (*rabeprazole sodium*)	Non Preferred	PA
DEXILANT ORAL CAPSULE DELAYED RELEASE 30 MG, 60 MG (*dexlansoprazole*)	Non Preferred	PA
KONVOMEP ORAL SUSPENSION RECONSTITUTED 2-84 MG/ML (*omeprazole-sodium bicarbonate*)	Non Preferred	PA; QL (2 ML per 1 day)
NEXIUM ORAL CAPSULE DELAYED RELEASE 20 MG, 40 MG (*esomeprazole magnesium*)	Non Preferred	PA; QL (2 EA per 1 day)
NEXIUM ORAL PACKET 10 MG, 2.5 MG, 20 MG, 40 MG, 5 MG (*esomeprazole magnesium*)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID 24HR ORAL CAPSULE DELAYED RELEASE 15 MG (*lansoprazole*)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID ORAL CAPSULE DELAYED RELEASE 30 MG (*lansoprazole*)	Non Preferred	PA; QL (2 EA per 1 day)
PREVACID SOLUTAB ORAL TABLET DELAYED RELEASE DISPERSIBLE 15 MG, 30 MG (*lansoprazole*)	Non Preferred	PA; QL (2 EA per 1 day)
PRILOSEC ORAL PACKET 10 MG, 2.5 MG (*omeprazole magnesium*)	Non Preferred	PA; QL (2 EA per 1 day)
PROTONIX ORAL TABLET DELAYED RELEASE 20 MG, 40 MG (*pantoprazole sodium*)	Non Preferred	PA; QL (2 EA per 1 day)
ZEGERID ORAL CAPSULE 20-1100 MG, 40-1100 MG (*omeprazole-sodium bicarbonate*)	Non Preferred	PA
ZEGERID ORAL PACKET 20-1680 MG, 40-1680 MG (*omeprazole-sodium bicarbonate*)	Non Preferred	PA
PSORIASIS: TOPICAL [OPEN CLASS]		
calcipotriene external cream 0.005 %	Preferred	
calcipotriene external ointment 0.005 %	Preferred	
calcipotriene external solution 0.005 %	Preferred	
calcipotriene external foam 0.005 %	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
calcipotriene-betameth diprop external ointment 0.005-0.064 %	Non Preferred	PA
calcipotriene-betameth diprop external suspension 0.005-0.064 %	Non Preferred	PA
calcitriol external ointment 3 mcg/gm	Non Preferred	PA; AGE (Max 18 Years)
BESER EXTERNAL KIT 0.05 % (*fluticasone-emollient*)	Non Preferred	PA
DUOBRII EXTERNAL LOTION 0.01-0.045 % (*halobetasol prop-tazarotene*)	Non Preferred	PA
ENSTILAR EXTERNAL FOAM 0.005-0.064 % (*calcipotriene-betameth diprop*)	Non Preferred	PA; AGE (Min 18 Years)
SORILUX EXTERNAL FOAM 0.005 % (*calcipotriene*)	Non Preferred	PA
TACLONEX EXTERNAL OINTMENT 0.005-0.064 % (*calcipotriene-betameth diprop*)	Non Preferred	PA
TACLONEX EXTERNAL SUSPENSION 0.005-0.064 % (*calcipotriene-betameth diprop*)	Non Preferred	PA
VTAMA EXTERNAL CREAM 1 % (*tapinarof*)	Non Preferred	PA; AGE (Min 18 Years)
ZORYVE EXTERNAL CREAM 0.3 % (*roflumilast*)	Non Preferred	PA; AGE (Min 6 Years)
PULMONARY ARTERIAL HYPERTENSION [OPEN CLASS]		
ambrisentan oral tablet 10 mg, 5 mg	Preferred	SP; QL (1 EA per 1 day); AGE (Min 18 Years)
bosentan oral tablet 125 mg, 62.5 mg	Preferred	SP; QL (2 EA per 1 day)
sildenafil citrate oral suspension reconstituted 10 mg/ml	Preferred	SP; PA; AGE (Min 1 Years)
sildenafil citrate oral tablet 20 mg	Preferred	SP; PA; AGE (Min 1 Years)
tadalafil (pah) oral tablet 20 mg	Preferred	SP; PA; AGE (Min 18 Years)
tadalafil (pah) (Alyq Oral Tablet 20 Mg)	Preferred	SP; PA; AGE (Min 18 Years)
TRACLEER ORAL TABLET 125 MG, 62.5 MG (*bosentan*)	Preferred	SP; QL (2 EA per 1 day)
VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML (*iloprost*)	Preferred	SP
ADCIRCA ORAL TABLET 20 MG (*tadalafil (pah)*)	Non Preferred	SP; PA; AGE (Min 18 Years)
ADEMPAS ORAL TABLET 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG (*riociguat*)	Non Preferred	SP; PA
LETAIRIS ORAL TABLET 10 MG, 5 MG (*ambrisentan*)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 18 Years)
LIQREV ORAL SUSPENSION 10 MG/ML (*sildenafil citrate*)	Non Preferred	SP; PA; AGE (Min 18 Years)
OPSUMIT ORAL TABLET 10 MG (*macitentan*)	Non Preferred	SP; PA
OPSYNVI ORAL TABLET 10-20 MG, 10-40 MG (*macitentan-tadalafil*)	Non Preferred	SP; PA; QL (1 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
ORENITRAM MONTH 1 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	Non Preferred	SP; PA
ORENITRAM MONTH 2 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 MG (*treprostinil diolamine*)	Non Preferred	SP; PA
ORENITRAM MONTH 3 ORAL TABLET EXTENDED RELEASE THERAPY PACK 0.125 & 0.25 &1 MG (*treprostinil diolamine*)	Non Preferred	SP; PA
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG, 0.25 MG, 1 MG, 2.5 MG, 5 MG (*treprostinil diolamine*)	Non Preferred	SP; PA
REVATIO ORAL SUSPENSION RECONSTITUTED 10 MG/ML (*sildenafil citrate*)	Non Preferred	SP; PA; AGE (Min 1 Years)
REVATIO ORAL TABLET 20 MG (*sildenafil citrate*)	Non Preferred	SP; PA; AGE (Min 1 Years)
TADLIQ ORAL SUSPENSION 20 MG/5ML (*tadalafil (pah)*)	Non Preferred	SP; PA; AGE (Min 18 Years)
TRACLEER ORAL TABLET SOLUBLE 32 MG (*bosentan*)	Non Preferred	SP; PA
TYVASO DPI INSTITUTIONAL KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (*treprostinil*)	Non Preferred	SP; PA
TYVASO DPI MAINTENANCE KIT INHALATION POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG (*treprostinil*)	Non Preferred	SP; PA
TYVASO DPI TITRATION KIT INHALATION POWDER 112 X 16MCG & 84 X 32MCG, 16 & 32 & 48 MCG (*treprostinil*)	Non Preferred	SP; PA
TYVASO INHALATION SOLUTION 0.6 MG/ML (*treprostinil*)	Non Preferred	SP; PA
TYVASO REFILL KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*)	Non Preferred	SP; PA
TYVASO STARTER KIT INHALATION SOLUTION 0.6 MG/ML (*treprostinil*)	Non Preferred	SP; PA
UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG (*selexipag*)	Non Preferred	SP; PA
UPTRAVI TITRATION ORAL TABLET THERAPY PACK 200 & 800 MCG (*selexipag*)	Non Preferred	SP; PA
QUINOLONES: ORAL [OPEN CLASS]		
ciprofloxacin hcl oral tablet 100 mg, 250 mg, 500 mg, 750 mg	Preferred	
ciprofloxacin oral suspension reconstituted 250 mg/5ml (5%), 500 mg/5ml (10%)	Preferred	
levofloxacin oral tablet 250 mg, 500 mg, 750 mg	Preferred	
levofloxacin oral solution 25 mg/ml	Non Preferred	PA
moxifloxacin hcl oral tablet 400 mg	Non Preferred	PA
ofloxacin oral tablet 300 mg, 400 mg	Non Preferred	PA
BAXDELA ORAL TABLET 450 MG (*delafloxacin meglumine*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
CIPRO ORAL SUSPENSION RECONSTITUTED 250 MG/5ML (5%), 500 MG/5ML (10%) (*ciprofloxacin*)	Non Preferred	PA
CIPRO ORAL TABLET 250 MG, 500 MG (*ciprofloxacin hcl*)	Non Preferred	PA
ROSACEA AGENTS: TOPICAL [OPEN CLASS]		
ivermectin external cream 1 %	Preferred	
metronidazole external cream 0.75 %	Preferred	
metronidazole external gel 0.75 %	Preferred	
metronidazole external lotion 0.75 %	Preferred	
metronidazole gel 1 % external	Preferred	
metronidazole (Rosadan External Cream 0.75 %)	Preferred	
metronidazole (Rosadan External Gel 0.75 %)	Preferred	
azelaic acid external gel 15 %	Non Preferred	PA; AGE (Min 18 Years)
brimonidine tartrate external gel 0.33 %	Non Preferred	PA
metronidazole gel 1 % external	Non Preferred	PA
FINACEA EXTERNAL FOAM 15 % (*azelaic acid*)	Non Preferred	PA; AGE (Min 18 Years)
FINACEA EXTERNAL GEL 15 % (*azelaic acid*)	Non Preferred	PA; AGE (Min 18 Years)
NORITATE EXTERNAL CREAM 1 % (*metronidazole*)	Non Preferred	PA
RHOFADE EXTERNAL CREAM 1 % (*oxymetazoline hcl*)	Non Preferred	PA
ROSADAN EXTERNAL KIT 0.75 % CREAM, 0.75 % GEL (*metronidazole-cleanser*)	Non Preferred	PA
SECOND GENERATION ANTIHISTAMINES AND COMBINATIONS [OPEN CLASS]		
12hr allergy & congestion oral tablet extended release 12 hour 60-120 mg	Preferred	
all day allergy childrens oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
all day allergy oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
allergy childrens oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
allergy rel child (loratadine) oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
allergy relief (loratadine) oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
allergy relief cetirizine oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
allergy relief childrens oral solution 1 mg/ml	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
allergy relief oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
allergy relief/indoor/outdoor oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
cetirizine hcl allergy child oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
cetirizine hcl childrens alrgy oral solution 1 mg/ml	Preferred	90-day fill allowed after two 1-month fills
cetirizine hcl oral solution 1 mg/ml, 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
cetirizine hcl oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
childrens loratadine oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
fexofenadine-pseudoephed er oral tablet extended release 12 hour 60-120 mg	Preferred	
ft all day allergy 24 hour oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
ft all day allergy childrens oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
ft all day allergy oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
ft all day allergy relief oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
ft allergy & congestion-d 12hr oral tablet extended release 12 hour 60-120 mg	Preferred	
ft allergy childrens oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
ft allergy relief cetirizine oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
ft allergy relief childrens oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
ft allergy relief loratadine oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
ft allergy relief oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
gnp all day allergy childrens oral solution 1 mg/ml, 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
gnp all day allergy oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
gnp allergy relief 24 hr oral tablet 5 mg	Preferred	90-day fill allowed after two 1-month fills
gnp fexofenadine/pse er oral tablet extended release 12 hour 60-120 mg	Preferred	
gnp loratadine childrens oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
gnp loratadine oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
gnp loratadine oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
gnp loratadine oral tablet dispersible 10 mg	Preferred	
goodsense all day allergy oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
goodsense all day allergy oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
goodsense allergy relief child oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
goodsense allergy relief oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
hm all day allergy childrens oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
hm all day allergy oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
hm allergy relief (cetirizine) oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
hm cetirizine hcl oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
hm loratadine oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
levocetirizine dihydrochloride oral tablet 5 mg	Preferred	90-day fill allowed after two 1-month fills
loratadine childrens oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
loratadine oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
loratadine oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
loratadine oral tablet dispersible 10 mg	Preferred	
sm all day allergy childrens oral solution 1 mg/ml, 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
sm all day allergy oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
sm all day allergy relief oral tablet 10 mg	Preferred	90-day fill allowed after two 1-month fills
sm allergy childrens oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
sm loratadine oral solution 5 mg/5ml	Preferred	AGE (Min 2 Years)
12hr allergy relief oral tablet 60 mg	Non Preferred	PA
24hr allergy relief oral tablet 180 mg	Non Preferred	PA
all day allergy-d oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
allergy 24-hr oral tablet 180 mg	Non Preferred	PA
allergy childrens oral suspension 30 mg/5ml	Non Preferred	PA
allergy relief (cetirizine) oral capsule 10 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
allergy relief d oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
allergy relief d-12 oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
allergy relief d-24 oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
allergy relief oral tablet 180 mg	Non Preferred	PA
allergy relief/nasal decongest oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
allergy relief/nasal decongest oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
allergy/congestion relief oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
cetirizine hcl childrens oral solution 5 mg/5ml	Non Preferred	PA
cetirizine hcl oral tablet chewable 10 mg, 5 mg	Non Preferred	PA
cetirizine-pseudoephedrine er oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
desloratadine oral tablet 5 mg	Non Preferred	PA
desloratadine oral tablet dispersible 2.5 mg, 5 mg	Non Preferred	PA
fexofenadine hcl oral tablet 180 mg, 60 mg	Non Preferred	PA
fexofenadine-pseudoephed er oral tablet extended release 24 hour 180-240 mg	Non Preferred	PA
ft all day allergy-d oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
ft allergy d-12 hour oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
ft allergy relief 12 hour oral tablet 60 mg	Non Preferred	PA
ft allergy relief 24 hour oral tablet 180 mg	Non Preferred	PA
ft allergy relief childrens oral tablet chewable 5 mg	Non Preferred	PA; AGE (Min 2 Years)
ft allergy relief oral tablet 180 mg	Non Preferred	PA
ft allergy relief-d oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
gnp all day allergy relief oral capsule 10 mg	Non Preferred	PA
gnp all day allergy-d oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
gnp allergy & congestion oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
gnp allergy relief oral tablet 180 mg	Non Preferred	PA
gnp allergy/congestion relief oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
goodsense all day allergy-d oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
goodsense aller-ease oral tablet 180 mg	Non Preferred	PA
hm allergy relief oral tablet 180 mg, 60 mg	Non Preferred	PA
hm allergy relief/nasal decong oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
levocetirizine dihydrochloride oral solution 2.5 mg/5ml	Non Preferred	PA
loratadine childrens oral tablet chewable 5 mg	Non Preferred	PA; AGE (Min 2 Years)
loratadine-d 12hr oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
loratadine-d 24hr oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
sm all day allergy-d oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
sm allergy relief oral tablet 60 mg	Non Preferred	PA
sm fexofenadine hcl oral tablet 180 mg	Non Preferred	PA
sm loratadine d 12hr oral tablet extended release 12 hour 5-120 mg	Non Preferred	PA
sm lorata-dine d oral tablet extended release 24 hour 10-240 mg	Non Preferred	PA
CLARINEX ORAL TABLET 5 MG (*desloratadine*)	Non Preferred	PA
CLARINEX-D 12 HOUR ORAL TABLET EXTENDED RELEASE 12 HOUR 2.5-120 MG (*desloratadine-pseudoephedrine*)	Non Preferred	PA
SEDATIVES: HYPNOTICS [OPEN CLASS]		
eszopiclone oral tablet 1 mg, 2 mg, 3 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
temazepam oral capsule 15 mg, 30 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
triazolam oral tablet 0.125 mg, 0.25 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
zaleplon oral capsule 10 mg, 5 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
zolpidem tartrate oral tablet 10 mg, 5 mg	Preferred	QL (1 EA per 1 day); AGE (Min 18 Years)
doxepin hcl oral tablet 3 mg, 6 mg	Non Preferred	PA; AGE (Min 18 Years)
estazolam oral tablet 1 mg, 2 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
flurazepam hcl oral capsule 15 mg, 30 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
quazepam oral tablet 15 mg	Non Preferred	PA
ramelteon oral tablet 8 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
tasimelteon oral capsule 20 mg	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 16 Years)
temazepam oral capsule 22.5 mg, 7.5 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
zolpidem tartrate er oral tablet extended release 12.5 mg, 6.25 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
zolpidem tartrate oral capsule 7.5 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
zolpidem tartrate sublingual tablet sublingual 1.75 mg, 3.5 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN CR ORAL TABLET EXTENDED RELEASE 12.5 MG, 6.25 MG (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
AMBIEN ORAL TABLET 10 MG, 5 MG (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
BELSOMRA ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG (*suvorexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DAYVIGO ORAL TABLET 10 MG, 5 MG (*lemborexant*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
DORAL ORAL TABLET 15 MG (*quazepam*)	Non Preferred	PA
EDLUAR SUBLINGUAL TABLET SUBLINGUAL 10 MG, 5 MG (*zolpidem tartrate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
HALCION ORAL TABLET 0.25 MG (*triazolam*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
HETLIOZ LQ ORAL SUSPENSION 4 MG/ML (*tasimelteon*)	Non Preferred	PA; QL (5 ML per 1 day); AGE (Min 3 Years and Max 15 Years)
HETLIOZ ORAL CAPSULE 20 MG (*tasimelteon*)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 16 Years)
LUNESTA ORAL TABLET 1 MG, 2 MG, 3 MG (*eszopiclone*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QUVIVIQ ORAL TABLET 25 MG, 50 MG (*daridorexant hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)

Drug Name	Formulary Status	Requirements/Limits
RESTORIL ORAL CAPSULE 15 MG, 22.5 MG, 30 MG, 7.5 MG (*temazepam*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
ROZEREM ORAL TABLET 8 MG (*ramelteon*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
SICKLE CELL ANEMIA TREATMENTS [CLOSED CLASS]		
DROXIA ORAL CAPSULE 200 MG, 300 MG, 400 MG (*hydroxyurea*)	Preferred	AGE (Min 18 Years)
ENDARI ORAL PACKET 5 GM (*glutamine (sickle cell)*)	Preferred	SP; AGE (Min 5 Years)
ADAKVEO INTRAVENOUS SOLUTION 100 MG/10ML (*crizanlizumab-tmca*)	Non Preferred	PA; AGE (Min 16 Years)
SIKLOS ORAL TABLET 100 MG, 1000 MG (*hydroxyurea*)	Non Preferred	SP; PA; AGE (Min 2 Years)
SKELETAL MUSCLE RELAXANTS [OPEN CLASS]		
baclofen oral solution 5 mg/5ml	Preferred	AGE (Min 12 Years)
baclofen oral tablet 10 mg, 15 mg, 20 mg, 5 mg	Preferred	AGE (Min 12 Years)
chlorzoxazone oral tablet 250 mg, 375 mg, 500 mg, 750 mg	Preferred	QL (4 EA per 1 day); AGE (Min 18 Years)
cyclobenzaprine hcl oral tablet 10 mg, 5 mg	Preferred	QL (3 EA per 1 day); AGE (Min 15 Years)
cyclobenzaprine hcl oral tablet 7.5 mg	Preferred	QL (4 EA per 1 day); AGE (Min 15 Years)
dantrolene sodium oral capsule 100 mg, 25 mg, 50 mg	Preferred	AGE (Min 5 Years)
methocarbamol oral tablet 500 mg, 750 mg	Preferred	AGE (Min 16 Years)
orphenadrine citrate er oral tablet extended release 12 hour 100 mg	Preferred	QL (2 EA per 1 day); AGE (Min 18 Years)
tizanidine hcl oral tablet 2 mg	Preferred	QL (4 EA per 1 day); AGE (Min 18 Years)
tizanidine hcl oral tablet 4 mg	Preferred	QL (9 EA per 1 day); AGE (Min 18 Years)
baclofen oral solution 10 mg/5ml	Non Preferred	PA; QL (40 ML per 1 day); AGE (Min 12 Years)
baclofen oral suspension 25 mg/5ml	Non Preferred	PA; AGE (Min 12 Years)
carisoprodol oral tablet 250 mg, 350 mg	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 16 Years)
carisoprodol-aspirin-codeine oral tablet 200-325-16 mg	Non Preferred	PA; AGE (Min 16 Years)
cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg, 30 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 15 Years)
metaxalone oral tablet 400 mg, 800 mg	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 13 Years)
norgesic forte oral tablet 50-770-60 mg	Non Preferred	PA
orphenadrine-asa-caffeine oral tablet 50-770-60 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
tizanidine hcl oral capsule 2 mg	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
tizanidine hcl oral capsule 4 mg	Non Preferred	PA; QL (9 EA per 1 day); AGE (Min 18 Years)
tizanidine hcl oral capsule 6 mg	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
AMRIX ORAL CAPSULE EXTENDED RELEASE 24 HOUR 15 MG, 30 MG (*cyclobenzaprine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 15 Years)
DANTRIUM ORAL CAPSULE 25 MG (*dantrolene sodium*)	Non Preferred	PA; AGE (Min 5 Years)
cyclobenzaprine hcl (Fexmid Oral Tablet 7.5 Mg)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 15 Years)
FLEQSUVY ORAL SUSPENSION 25 MG/5ML (*baclofen*)	Non Preferred	PA; AGE (Min 12 Years)
chlorzoxazone (Lorzone Oral Tablet 375 Mg, 750 Mg)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
LYVISPAH ORAL PACKET 10 MG, 20 MG, 5 MG (*baclofen*)	Non Preferred	PA; AGE (Min 12 Years)
orphenadrine-aspirin-caffeine (Norgesic Oral Tablet 25-385-30 Mg)	Non Preferred	PA
orphenadrine-aspirin-caffeine (Orphengesic Forte Oral Tablet 50-770-60 Mg)	Non Preferred	PA
SOMA ORAL TABLET 250 MG, 350 MG (*carisoprodol*)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 16 Years)
TANLOR ORAL TABLET 1000 MG (*methocarbamol*)	Non Preferred	PA
ZANAFLEX ORAL CAPSULE 2 MG (*tizanidine hcl*)	Non Preferred	PA; QL (4 EA per 1 day); AGE (Min 18 Years)
ZANAFLEX ORAL CAPSULE 4 MG (*tizanidine hcl*)	Non Preferred	PA; QL (9 EA per 1 day); AGE (Min 18 Years)
ZANAFLEX ORAL CAPSULE 6 MG (*tizanidine hcl*)	Non Preferred	PA; QL (6 EA per 1 day); AGE (Min 18 Years)
ZANAFLEX ORAL TABLET 4 MG (*tizanidine hcl*)	Non Preferred	PA; QL (9 EA per 1 day); AGE (Min 18 Years)
SMOKING CESSATION [OPEN CLASS]		
bupropion hcl er (smoking det) oral tablet extended release 12 hour 150 mg	Preferred	90-day fill allowed after two 1-month fills
ft nicotine mini mouth/throat lozenge 2 mg, 4 mg	Preferred	
ft nicotine mouth/throat gum 2 mg, 4 mg	Preferred	
ft nicotine mouth/throat lozenge 2 mg, 4 mg	Preferred	
gnp nicotine mini mouth/throat lozenge 2 mg, 4 mg	Preferred	
gnp nicotine mouth/throat gum 2 mg, 4 mg	Preferred	
gnp nicotine polacrilex mouth/throat gum 2 mg, 4 mg	Preferred	
gnp nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
gnp nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	Preferred	
goodsense nicotine mouth/throat gum 2 mg, 4 mg	Preferred	
goodsense nicotine mouth/throat lozenge 2 mg, 4 mg	Preferred	
hm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	Preferred	
hm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	Preferred	
nicotine mini mouth/throat lozenge 2 mg, 4 mg	Preferred	
nicotine polacrilex mini mouth/throat lozenge 2 mg	Preferred	
nicotine polacrilex mouth/throat gum 2 mg, 4 mg	Preferred	
nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	Preferred	
nicotine step 1 transdermal patch 24 hour 21 mg/24hr	Preferred	
nicotine step 2 transdermal patch 24 hour 14 mg/24hr	Preferred	
nicotine step 3 transdermal patch 24 hour 7 mg/24hr	Preferred	
nicotine transdermal kit 21-14-7 mg/24hr	Preferred	
nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	Preferred	
sm nicotine mouth/throat gum 4 mg	Preferred	
sm nicotine mouth/throat lozenge 2 mg	Preferred	
sm nicotine polacrilex mouth/throat gum 2 mg, 4 mg	Preferred	
sm nicotine polacrilex mouth/throat lozenge 2 mg, 4 mg	Preferred	
sm nicotine transdermal patch 24 hour 14 mg/24hr, 21 mg/24hr, 7 mg/24hr	Preferred	
varenicline tartrate (starter) oral tablet therapy pack 0.5 mg x 11 & 1 mg x 42	Preferred	
varenicline tartrate oral tablet 0.5 mg, 1 mg	Preferred	
varenicline tartrate(continue) oral tablet 1 mg	Preferred	
CHANTIX CONTINUING MONTH PAK ORAL TABLET 1 MG (*varenicline tartrate*)	Preferred	
CHANTIX ORAL TABLET 1 MG (*varenicline tartrate*)	Preferred	
CHANTIX STARTING MONTH PAK ORAL TABLET THERAPY PACK 0.5 MG X 11 & 1 MG X 42 (*varenicline tartrate*)	Preferred	
NICOTROL INHALATION INHALER 10 MG (*nicotine*)	Non Preferred	PA
NICOTROL NS NASAL SOLUTION 10 MG/ML (*nicotine*)	Non Preferred	PA
STEROIDS: TOPICAL, HIGH POTENCY [OPEN CLASS]		
betamethasone dipropionate aug external cream 0.05 %	Preferred	
betamethasone valerate external cream 0.1 %	Preferred	
betamethasone valerate external lotion 0.1 %	Preferred	
betamethasone valerate external ointment 0.1 %	Preferred	
triamcinolone acetonide external cream 0.025 %, 0.1 %, 0.5 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
triamcinolone acetonide external lotion 0.025 %, 0.1 %	Preferred	
triamcinolone acetonide external ointment 0.025 %, 0.05 %, 0.1 %, 0.5 %	Preferred	
triamcinolone in absorbase external ointment 0.05 %	Preferred	
amcinonide external cream 0.1 %	Non Preferred	PA
betamethasone dipropionate aug external gel 0.05 %	Non Preferred	PA
betamethasone dipropionate aug external lotion 0.05 %	Non Preferred	PA
betamethasone dipropionate aug external ointment 0.05 %	Non Preferred	PA
betamethasone dipropionate external cream 0.05 %	Non Preferred	PA
betamethasone dipropionate external lotion 0.05 %	Non Preferred	PA
betamethasone dipropionate external ointment 0.05 %	Non Preferred	PA
desoximetasone external cream 0.05 %, 0.25 %	Non Preferred	PA
desoximetasone external gel 0.05 %	Non Preferred	PA
desoximetasone external liquid 0.25 %	Non Preferred	PA
desoximetasone external ointment 0.05 %, 0.25 %	Non Preferred	PA
diflorasone diacetate external cream 0.05 %	Non Preferred	PA
diflorasone diacetate external ointment 0.05 %	Non Preferred	PA
fluocinonide emulsified base external cream 0.05 %	Non Preferred	PA
fluocinonide external cream 0.05 %, 0.1 %	Non Preferred	PA
fluocinonide external gel 0.05 %	Non Preferred	PA
fluocinonide external ointment 0.05 %	Non Preferred	PA
fluocinonide external solution 0.05 %	Non Preferred	PA
halcinonide external cream 0.1 %	Non Preferred	PA
triamcinolone acetonide external aerosol solution 0.147 mg/gm	Non Preferred	PA
DIPROLENE EXTERNAL OINTMENT 0.05 % (*betamethasone dipropionate aug*)	Non Preferred	PA

AGE - Age Limit **EA** - Each **Max** - Maximum **Min** - Minimum **ML** - Milliliter **OTC** - Over-the-Counter Drug
PA - Prior Authorization **ST** - Step Therapy **QL** - Quantity Limits **RX** - Prescription Drug **SP** - Specialty Drug

Drug Name	Formulary Status	Requirements/Limits
HALOG EXTERNAL CREAM 0.1 % (*halcinonide*)	Non Preferred	PA
HALOG EXTERNAL OINTMENT 0.1 % (*halcinonide*)	Non Preferred	PA
HALOG EXTERNAL SOLUTION 0.1 % (*halcinonide*)	Non Preferred	PA
KENALOG EXTERNAL AEROSOL SOLUTION 0.147 MG/GM (*triamcinolone acetonide*)	Non Preferred	PA
TOPICORT EXTERNAL CREAM 0.05 %, 0.25 % (*desoximetasone*)	Non Preferred	PA
TOPICORT EXTERNAL GEL 0.05 % (*desoximetasone*)	Non Preferred	PA
TOPICORT EXTERNAL OINTMENT 0.05 %, 0.25 % (*desoximetasone*)	Non Preferred	PA
TOPICORT SPRAY EXTERNAL LIQUID 0.25 % (*desoximetasone*)	Non Preferred	PA
VANOS EXTERNAL CREAM 0.1 % (*fluocinonide*)	Non Preferred	PA
STEROIDS: TOPICAL, LOW POTENCY [OPEN CLASS]		
anti-itch maximum strength external cream 1 %	Preferred	
ft itch relief max strength external cream 1 %	Preferred	
ft itch relief max strength external ointment 1 %	Preferred	
ft itch relief/aloe max str external cream 1 %	Preferred	
gnp hydrocortisone external cream 0.5 %	Preferred	
gnp hydrocortisone max st external ointment 1 %	Preferred	
gnp hydrocortisone plus external cream 1 %	Preferred	
gnp hydrocortisone/aloe external cream 1 %	Preferred	
hm hydrocortisone plus external cream 1 %	Preferred	
hm hydrocortisone-aloe max st external cream 1 %	Preferred	
hydrocortisone (perianal) external cream 2.5 %	Preferred	
hydrocortisone acetate external cream 1 %	Preferred	
hydrocortisone acetate external ointment 1 %	Preferred	
hydrocortisone cream 1 % external (otc)	Preferred	
hydrocortisone cream 1 % external (rx)	Preferred	
hydrocortisone external cream 0.5 %, 2.5 %	Preferred	
hydrocortisone external lotion 2.5 %	Preferred	
hydrocortisone external ointment 2.5 %	Preferred	
hydrocortisone max st external cream 1 %	Preferred	
hydrocortisone max st/12 moist external cream 1 %	Preferred	
hydrocortisone ointment 1 % external (otc)	Preferred	
hydrocortisone ointment 1 % external (rx)	Preferred	
hydrocortisone/aloe max str external cream 1 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
sm hydrocortisone external cream 1 %	Preferred	
sm hydrocortisone max st external ointment 1 %	Preferred	
sm hydrocortisone plus external cream 1 %	Preferred	
hydrocortisone (Proctocort External Cream 1 %)	Preferred	
hydrocortisone (Procto-Med Hc External Cream 2.5 %)	Preferred	
hydrocortisone (Proctosol Hc External Cream 2.5 %)	Preferred	
hydrocortisone (Proctozone-Hc External Cream 2.5 %)	Preferred	
alclometasone dipropionate external cream 0.05 %	Non Preferred	PA
alclometasone dipropionate external ointment 0.05 %	Non Preferred	PA
desonide external cream 0.05 %	Non Preferred	PA
desonide external lotion 0.05 %	Non Preferred	PA
desonide external ointment 0.05 %	Non Preferred	PA
fluocinolone acetonide body external oil 0.01 %	Non Preferred	PA
fluocinolone acetonide scalp external oil 0.01 %	Non Preferred	PA
hydrocortisone complete kit external therapy pack 2 %	Non Preferred	PA
ANUSOL-HC EXTERNAL CREAM 2.5 % (*hydrocortisone*)	Non Preferred	PA
DERMA-SMOOTHE/FS BODY EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	Non Preferred	PA
DERMA-SMOOTHE/FS SCALP EXTERNAL OIL 0.01 % (*fluocinolone acetonide*)	Non Preferred	PA
TEXACORT EXTERNAL SOLUTION 2.5 % (*hydrocortisone*)	Non Preferred	PA
STEROIDS: TOPICAL, MEDIUM POTENCY [OPEN CLASS]		
fluticasone propionate external cream 0.05 %	Preferred	
fluticasone propionate external ointment 0.005 %	Preferred	
mometasone furoate external cream 0.1 %	Preferred	
mometasone furoate external ointment 0.1 %	Preferred	
mometasone furoate external solution 0.1 %	Preferred	
betamethasone valerate external foam 0.12 %	Non Preferred	PA
clocortolone pivalate external cream 0.1 %	Non Preferred	PA
fluocinolone acetonide external cream 0.01 %, 0.025 %	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
fluocinolone acetonide external ointment 0.025 %	Non Preferred	PA
fluocinolone acetonide external solution 0.01 %	Non Preferred	PA
flurandrenolide external lotion 0.05 %	Non Preferred	PA
flurandrenolide external ointment 0.05 %	Non Preferred	PA
fluticasone propionate external lotion 0.05 %	Non Preferred	PA
hydrocortisone butyr lipo base external cream 0.1 %	Non Preferred	PA
hydrocortisone butyrate external cream 0.1 %	Non Preferred	PA
hydrocortisone butyrate external lotion 0.1 %	Non Preferred	PA
hydrocortisone butyrate external ointment 0.1 %	Non Preferred	PA
hydrocortisone butyrate external solution 0.1 %	Non Preferred	PA
hydrocortisone valerate external cream 0.2 %	Non Preferred	PA
hydrocortisone valerate external ointment 0.2 %	Non Preferred	PA
prednicarbate external cream 0.1 %	Non Preferred	PA
prednicarbate external ointment 0.1 %	Non Preferred	PA
triamcinolone acetonide mouth/throat paste 0.1 %	Non Preferred	PA
fluticasone propionate (Beser External Lotion 0.05 %)	Non Preferred	PA
CLODERM EXTERNAL CREAM 0.1 % (*clocortolone pivalate*)	Non Preferred	PA
LOCOID EXTERNAL LOTION 0.1 % (*hydrocortisone butyrate*)	Non Preferred	PA
LOCOID LIPOCREAM EXTERNAL CREAM 0.1 % (*hydrocortisone butyr lipo base*)	Non Preferred	PA
triamcinolone acetonide (Oralone Mouth/Throat Paste 0.1 %)	Non Preferred	PA
PANDEL EXTERNAL CREAM 0.1 % (*hydrocortisone probutate*)	Non Preferred	PA
SYNALAR (CREAM) EXTERNAL KIT 0.025 % (*fluocinolone-emollient*)	Non Preferred	PA
SYNALAR (OINTMENT) EXTERNAL KIT 0.025 % (*fluocinolone-emollient*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
SYNALAR EXTERNAL CREAM 0.025 % (*fluocinolone acetonide*)	Non Preferred	PA
SYNALAR EXTERNAL OINTMENT 0.025 % (*fluocinolone acetonide*)	Non Preferred	PA
SYNALAR EXTERNAL SOLUTION 0.01 % (*fluocinolone acetonide*)	Non Preferred	PA
SYNALAR TS EXTERNAL KIT 0.01 % (*fluocinolone & cleanser*)	Non Preferred	PA
STEROIDS: TOPICAL, VERY HIGH POTENCY [OPEN CLASS]		
clobetasol prop emollient base external cream 0.05 %	Preferred	
clobetasol propionate e external cream 0.05 %	Preferred	
clobetasol propionate external cream 0.05 %	Preferred	
clobetasol propionate external gel 0.05 %	Preferred	
clobetasol propionate external ointment 0.05 %	Preferred	
clobetasol propionate external solution 0.05 %	Preferred	
halobetasol propionate external cream 0.05 %	Preferred	
clobetasol propionate emulsion external foam 0.05 %	Non Preferred	PA
clobetasol propionate external foam 0.05 %	Non Preferred	PA
clobetasol propionate external liquid 0.05 %	Non Preferred	PA
clobetasol propionate external lotion 0.05 %	Non Preferred	PA
clobetasol propionate external shampoo 0.05 %	Non Preferred	PA
halobetasol propionate external foam 0.05 %	Non Preferred	PA
halobetasol propionate external ointment 0.05 %	Non Preferred	PA
APEXICON E EXTERNAL CREAM 0.05 % (*diflorasone diacet emoll base*)	Non Preferred	PA
BRYHALI EXTERNAL LOTION 0.01 % (*halobetasol propionate*)	Non Preferred	PA
CLODAN EXTERNAL KIT 0.05 % (*clobetasol prop & cleanser*)	Non Preferred	PA
clobetasol propionate (Clodan External Shampoo 0.05 %)	Non Preferred	PA
IMPEKLO EXTERNAL LOTION 0.15 MG/ACT (0.05%) (*clobetasol propionate*)	Non Preferred	PA
LEXETTE EXTERNAL FOAM 0.05 % (*halobetasol propionate*)	Non Preferred	PA
OLUX EXTERNAL FOAM 0.05 % (*clobetasol propionate*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
TEMOVATE EXTERNAL OINTMENT 0.05 % (*clobetasol propionate*)	Non Preferred	PA
clobetasol propionate emulsion (Tovet External Foam 0.05 %)	Non Preferred	PA
TOVET EXTERNAL KIT 0.05 % (*clobetasol emul foam w/moistcr*)	Non Preferred	PA
ULTRAVATE EXTERNAL LOTION 0.05 % (*halobetasol propionate*)	Non Preferred	PA
STIMULANTS AND RELATED AGENTS [CLOSED CLASS]		
amphetamine-dextroamphet er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphet er oral capsule extended release 24 hour 20 mg, 25 mg, 30 mg	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
amphetamine-dextroamphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	Preferred	AGE (Min 4 Years and Max 17 Years)
armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
atomoxetine hcl oral capsule 10 mg, 100 mg, 18 mg, 25 mg, 40 mg, 60 mg, 80 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
clonidine hcl er oral tablet extended release 12 hour 0.1 mg	Preferred	90-day fill allowed after two 1-month fills
dexmethylphenidate hcl er oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg, 5 mg	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
dexmethylphenidate hcl oral tablet 10 mg, 2.5 mg, 5 mg	Preferred	AGE (Min 4 Years and Max 17 Years)
dextroamphetamine sulfate er oral capsule extended release 24 hour 10 mg, 15 mg, 5 mg	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 2.5 mg, 20 mg, 30 mg, 5 mg, 7.5 mg	Preferred	AGE (Min 4 Years and Max 17 Years)
guanfacine hcl er oral tablet extended release 24 hour 1 mg, 2 mg, 3 mg, 4 mg	Preferred	90-day fill allowed after two 1-month fills
methylphenidate hcl oral solution 10 mg/5ml, 5 mg/5ml	Preferred	AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl oral tablet 10 mg, 20 mg, 5 mg	Preferred	AGE (Min 4 Years and Max 17 Years)
modafinil oral tablet 100 mg, 200 mg	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
CONCERTA ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 54 MG (*methylphenidate hcl*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
CONCERTA ORAL TABLET EXTENDED RELEASE 36 MG (*methylphenidate hcl*)	Preferred	QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DAYTRANA TRANSDERMAL PATCH 10 MG/9HR, 15 MG/9HR, 20 MG/9HR, 30 MG/9HR (*methylphenidate*)	Preferred	QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
SUNOSI ORAL TABLET 150 MG, 75 MG (*solriamfetol hcl*)	Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG (*lisdexamfetamine dimesylate*)	Preferred	QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
amphetamine sulfate oral tablet 10 mg, 5 mg	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
amphet-dextroamphet 3-bead er oral capsule extended release 24 hour 12.5 mg, 25 mg, 37.5 mg, 50 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
dextroamphetamine sulfate oral solution 5 mg/5ml	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
lisdexamfetamine dimesylate oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
lisdexamfetamine dimesylate oral tablet chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
methamphetamine hcl oral tablet 5 mg	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (cd) oral capsule extended release 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (la) oral capsule extended release 24 hour 10 mg, 20 mg, 30 mg, 40 mg, 60 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (osm) oral tablet extended release 18 mg, 27 mg, 45 mg, 54 mg, 63 mg, 72 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (osm) oral tablet extended release 36 mg	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er (xr) oral capsule extended release 24 hour 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er oral tablet extended release 10 mg, 20 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl er oral tablet extended release 24 hour 18 mg, 27 mg, 54 mg	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
methylphenidate hcl er oral tablet extended release 24 hour 36 mg	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
methylphenidate hcl oral tablet chewable 10 mg, 2.5 mg, 5 mg	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
methylphenidate transdermal patch 10 mg/9hr, 15 mg/9hr, 20 mg/9hr, 30 mg/9hr	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL ORAL TABLET 10 MG, 12.5 MG, 15 MG, 20 MG, 30 MG, 5 MG, 7.5 MG (*amphetamine-dextroamphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 5 MG (*amphetamine-dextroamphetamine*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADDERALL XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 20 MG, 25 MG, 30 MG (*amphetamine-dextroamphetamine*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
ADZENYS XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 12.5 MG, 15.7 MG, 18.8 MG, 3.1 MG, 6.3 MG, 9.4 MG (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
APTENSIO XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
AZSTARYS ORAL CAPSULE 26.1-5.2 MG, 39.2-7.8 MG, 52.3-10.4 MG (*serdexmethylphen-dexmethylphen*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
COTEMPLA XR-ODT ORAL TABLET EXTENDED RELEASE DISPERSIBLE 17.3 MG, 25.9 MG, 8.6 MG (*methylphenidate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DEXEDRINE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG (*dextroamphetamine sulfate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR ORAL SUSPENSION EXTENDED RELEASE 2.5 MG/ML (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
DYANAVEL XR ORAL TABLET CHEWABLE EXTENDED RELEASE 10 MG, 15 MG, 20 MG, 5 MG (*amphetamine*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ODT ORAL TABLET DISPERSIBLE 10 MG, 15 MG, 20 MG, 5 MG (*amphetamine sulfate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
EVEKEO ORAL TABLET 10 MG, 5 MG (*amphetamine sulfate*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN ORAL TABLET 10 MG, 2.5 MG, 5 MG (*dexmethylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
FOCALIN XR ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 15 MG, 20 MG, 25 MG, 30 MG, 35 MG, 40 MG, 5 MG (*dexmethylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
INTUNIV ORAL TABLET EXTENDED RELEASE 24 HOUR 1 MG, 2 MG, 3 MG, 4 MG (*guanfacine hcl*)	Non Preferred	PA
JORNAY PM ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 20 MG, 40 MG, 60 MG, 80 MG (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)

Drug Name	Formulary Status	Requirements/Limits
METHYLIN ORAL SOLUTION 10 MG/5ML, 5 MG/5ML (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
MYDAYIS ORAL CAPSULE EXTENDED RELEASE 24 HOUR 12.5 MG, 25 MG, 37.5 MG, 50 MG (*amphetamine-dextroamphetamine*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
NUVIGIL ORAL TABLET 150 MG, 200 MG, 250 MG, 50 MG (*armodafinil*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
dextroamphetamine sulfate (Procentra Oral Solution 5 Mg/5Ml)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
PROVIGIL ORAL TABLET 100 MG, 200 MG (*modafinil*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 18 Years)
QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG (*viloxazine hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years)
QUILLICHEW ER ORAL TABLET CHEWABLE EXTENDED RELEASE 20 MG, 30 MG, 40 MG (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
QUILLIVANT XR ORAL SUSPENSION RECONSTITUTED ER 25 MG/5ML (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
RELEXXII ORAL TABLET EXTENDED RELEASE 18 MG, 27 MG, 45 MG, 54 MG, 63 MG, 72 MG (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RELEXXII ORAL TABLET EXTENDED RELEASE 36 MG (*methylphenidate hcl*)	Non Preferred	PA; QL (2 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 10 MG, 20 MG, 30 MG, 40 MG (*methylphenidate hcl*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 4 Years and Max 17 Years)
RITALIN ORAL TABLET 10 MG, 20 MG, 5 MG (*methylphenidate hcl*)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
STRATTERA ORAL CAPSULE 10 MG, 100 MG, 18 MG, 25 MG, 40 MG, 60 MG, 80 MG (*atomoxetine hcl*)	Non Preferred	PA; QL (1 EA per 1 day)
VYVANSE ORAL TABLET CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG (*lisdexamfetamine dimesylate*)	Non Preferred	PA; QL (1 EA per 1 day); AGE (Min 6 Years and Max 17 Years)
WAKIX ORAL TABLET 17.8 MG, 4.45 MG (*pitolisant hcl*)	Non Preferred	SP; PA; QL (1 EA per 1 day); AGE (Min 18 Years)
XELSTRYM TRANSDERMAL PATCH 13.5 MG/9HR, 18 MG/9HR, 4.5 MG/9HR, 9 MG/9HR (*dextroamphetamine*)	Non Preferred	PA; AGE (Min 6 Years and Max 17 Years)
dextroamphetamine sulfate (Zenzedi Oral Tablet 10 Mg, 15 Mg, 2.5 Mg, 20 Mg, 30 Mg, 5 Mg, 7.5 Mg)	Non Preferred	PA; AGE (Min 4 Years and Max 17 Years)
SUPPLEMENTAL		
ACNE PRODUCTS**		
isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg	Preferred	PA; QL (2 EA per 1 day)
isotretinoin (Amnesteem Oral Capsule 10 Mg, 20 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
isotretinoin (Claravis Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
isotretinoin (Zenatane Oral Capsule 10 Mg, 20 Mg, 30 Mg, 40 Mg)	Preferred	PA; QL (2 EA per 1 day)
ALCOHOL DETERRENTS**		
acamprosate calcium oral tablet delayed release 333 mg	Preferred	
disulfiram oral tablet 250 mg, 500 mg	Preferred	
ALTERNATIVE MEDICINE - CO'S**		
co q-10 oral capsule 50 mg	Preferred	
coenzyme q-10 oral capsule 200 mg, 30 mg	Preferred	
sm coenzyme q-10 oral capsule 100 mg	Preferred	
ALTERNATIVE MEDICINE - ME'S**		
melatonin oral tablet 3 mg, 5 mg	Preferred	
sm melatonin oral tablet 3 mg	Preferred	
AMINOPENICILLINS**		
amoxicillin oral capsule 250 mg, 500 mg	Preferred	
amoxicillin oral suspension reconstituted 125 mg/5ml, 200 mg/5ml, 250 mg/5ml, 400 mg/5ml	Preferred	
amoxicillin oral tablet 500 mg, 875 mg	Preferred	
amoxicillin oral tablet chewable 125 mg, 250 mg	Preferred	
ANALGESIC COMBINATIONS**		
ft migraine relief oral tablet 250-250-65 mg	Preferred	
gnp headache relief extra str oral tablet 250-250-65 mg	Preferred	
gnp migraine relief oral tablet 250-250-65 mg	Preferred	
goodsense migraine formula oral tablet 250-250-65 mg	Preferred	
headache formula oral tablet 250-250-65 mg	Preferred	
headache relief oral tablet 250-250-65 mg	Preferred	
hm migraine relief oral tablet 250-250-65 mg	Preferred	
migraine relief oral tablet 250-250-65 mg	Preferred	
pain reliever plus oral tablet 250-250-65 mg	Preferred	
sm migraine relief oral tablet 250-250-65 mg	Preferred	
ANALGESICS OTHER**		
8 hour pain reliever oral tablet extended release 650 mg	Preferred	
acetaminophen childrens oral solution 160 mg/5ml	Preferred	
acetaminophen childrens oral suspension 160 mg/5ml	Preferred	
acetaminophen childrens oral tablet chewable 160 mg	Preferred	
acetaminophen er oral tablet extended release 650 mg	Preferred	
acetaminophen extra strength oral tablet 500 mg	Preferred	
acetaminophen infants oral suspension 160 mg/5ml	Preferred	
acetaminophen oral liquid 160 mg/5ml	Preferred	
acetaminophen oral solution 160 mg/5ml, 325 mg/10.15ml, 650 mg/20.3ml	Preferred	
acetaminophen oral suspension 160 mg/5ml, 650 mg/20.3ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
acetaminophen oral tablet 325 mg, 500 mg	Preferred	
acetaminophen oral tablet chewable 160 mg	Preferred	
acetaminophen rectal suppository 120 mg, 650 mg	Preferred	
arthritis pain relief oral tablet extended release 650 mg	Preferred	
ed-apap oral liquid 160 mg/5ml	Preferred	
ft 8 hour pain relief oral tablet extended release 650 mg	Preferred	
ft arthritis pain reliever oral tablet extended release 650 mg	Preferred	
ft children's pain/fever oral tablet chewable 160 mg	Preferred	
ft pain & fever childrens oral suspension 160 mg/5ml	Preferred	
ft pain & fever infants oral suspension 160 mg/5ml	Preferred	
ft pain relief adult extra st oral tablet 500 mg	Preferred	
ft pain relief extra strength oral tablet 500 mg	Preferred	
ft pain relief oral tablet 325 mg	Preferred	
ft pain reliever ex str adult oral tablet 500 mg	Preferred	
gnp 8 hour arthritis relief oral tablet extended release 650 mg	Preferred	
gnp 8 hour pain relief oral tablet extended release 650 mg	Preferred	
gnp 8 hour pain reliever oral tablet extended release 650 mg	Preferred	
gnp acetaminophen oral tablet 325 mg	Preferred	
gnp acetaminophen oral tablet chewable 160 mg	Preferred	
gnp infants pain/fever oral suspension 160 mg/5ml	Preferred	
gnp pain & fever childrens oral suspension 160 mg/5ml	Preferred	
gnp pain & fever infants oral suspension 160 mg/5ml	Preferred	
gnp pain relief extra strength oral tablet 500 mg	Preferred	
gnp pain relief oral tablet 325 mg	Preferred	
goodsense arthritis pain oral tablet extended release 650 mg	Preferred	
goodsense pain & fever child oral suspension 160 mg/5ml	Preferred	
goodsense pain & fever infants oral suspension 160 mg/5ml	Preferred	
goodsense pain relief extra st oral tablet 500 mg	Preferred	
goodsense pain relief oral tablet 325 mg	Preferred	
hm arthritis pain relief oral tablet extended release 650 mg	Preferred	
hm pain relief oral tablet extended release 650 mg	Preferred	
liquid acetaminophen oral liquid 160 mg/5ml	Preferred	
mapap oral capsule 500 mg	Preferred	
m-pap oral liquid 160 mg/5ml	Preferred	
pain & fever childrens oral suspension 160 mg/5ml	Preferred	
pain & fever infants oral suspension 160 mg/5ml	Preferred	
pain and fever relief kids oral liquid 160 mg/5ml	Preferred	
sm 8 hour pain relief oral tablet extended release 650 mg	Preferred	
sm arthritis pain relief oral tablet extended release 650 mg	Preferred	
sm arthritis pain reliever oral tablet extended release 650 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
sm pain & fever childrens oral suspension 160 mg/5ml	Preferred	
sm pain & fever infants oral suspension 160 mg/5ml	Preferred	
sm pain relief extra strength oral tablet 500 mg	Preferred	
sm pain reliever ex st oral tablet 500 mg	Preferred	
sm pain reliever oral tablet 325 mg	Preferred	
sm rapid melts junior oral tablet dispersible 160 mg	Preferred	
FEVERALL ADULTS RECTAL SUPPOSITORY 650 MG (*acetaminophen*)	Preferred	
FEVERALL CHILDRENS RECTAL SUPPOSITORY 120 MG (*acetaminophen*)	Preferred	
FEVERALL INFANTS RECTAL SUPPOSITORY 80 MG (*acetaminophen*)	Preferred	
FEVERALL JUNIOR STRENGTH RECTAL SUPPOSITORY 325 MG (*acetaminophen*)	Preferred	
MAPAP ACETAMINOPHEN EXTRA STR ORAL LIQUID 500 MG/15ML (*acetaminophen*)	Preferred	
MAPAP CHILDRENS ORAL TABLET CHEWABLE 160 MG, 80 MG (*acetaminophen*)	Preferred	
ANALGESICS-SEDATIVES**		
butalbital-acetaminophen oral tablet 50-325 mg	Preferred	QL (6 EA per 1 day)
butalbital-apap-caffeine oral tablet 50-325-40 mg	Preferred	QL (6 EA per 1 day)
butalbital-aspirin-caffeine oral capsule 50-325-40 mg	Preferred	QL (6 EA per 1 day)
butalbital-apap-caffeine (Bac Oral Tablet 50-325-40 Mg)	Preferred	QL (6 EA per 1 day)
ANDROGEN BIOSYNTHESIS INHIBITORS**		
abiraterone acetate oral tablet 250 mg	Preferred	SP; PA; QL (4 EA per 1 day)
abiraterone acetate oral tablet 500 mg	Preferred	SP; PA; QL (2 EA per 1 day)
ANDROGENS**		
testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml	Preferred	
testosterone cypionate (Depo-Testosterone Intramuscular Solution 100 Mg/Ml, 200 Mg/Ml)	Preferred	
ANESTHETICS TOPICAL ORAL - COMBINATIONS**		
sore throat mouth/throat lozenge 15-3.6 mg	Preferred	
ANESTHETICS TOPICAL ORAL**		
lidocaine viscous hcl mouth/throat solution 2 %	Preferred	
ANTACID & SIMETHICONE**		
alum & mag hydroxide-simeth oral suspension 1200-1200-120 mg/30ml	Preferred	
antacid & antigas oral suspension 2400-2400-240 mg/30ml	Preferred	
antacid maximum strength oral suspension 400-400-40 mg/5ml, 800-800-80 mg/10ml	Preferred	
antacid oral suspension 400-400-40 mg/10ml	Preferred	
antacid regular strength oral suspension 200-200-20 mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
antacid/antigas oral suspension 400-400-40 mg/10ml	Preferred	
ft antacid & antigas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml	Preferred	
gnp antacid & anti-gas oral suspension 200-200-20 mg/5ml, 400-400-40 mg/5ml	Preferred	
gnp antacid & anti-gas oral tablet chewable 1000-60 mg	Preferred	
gnp antacid regular strength oral suspension 200-200-20 mg/5ml	Preferred	
mag-al plus oral liquid 200-200-20 mg/5ml	Preferred	
mag-al plus xs oral liquid 400-400-40 mg/5ml	Preferred	
mintox maximum strength oral suspension 400-400-40 mg/5ml	Preferred	
sm antacid advanced oral suspension 200-200-20 mg/5ml	Preferred	
sm antacid anti-gas oral suspension 200-200-20 mg/5ml	Preferred	
sm antacid maximum strength oral suspension 400-400-40 mg/5ml	Preferred	
sm antacid oral suspension 400-400-40 mg/10ml	Preferred	
ALMACONE DOUBLE STRENGTH ORAL SUSPENSION 400-400-40 MG/5ML (*alum & mag hydroxide-simeth*)	Preferred	
MINTOX PLUS ORAL TABLET CHEWABLE 200-200-25 MG (*alum & mag hydroxide-simeth*)	Preferred	
ANTACID COMBINATIONS**		
antacid extra strength oral tablet chewable 160-105 mg	Preferred	
gnp antacid extra strength oral tablet chewable 160-105 mg	Preferred	
heartburn relief ex st oral suspension 254-237.5 mg/5ml	Preferred	
mag-al oral liquid 200-200 mg/5ml	Preferred	
ACID GONE ORAL SUSPENSION 95-358 MG/15ML (*alum hydroxide-mag carbonate*)	Preferred	
ACID GONE ORAL TABLET CHEWABLE 160-105 MG (*alum hydroxide-mag carbonate*)	Preferred	
ANTACIDS - ALUMINUM SALTS**		
aluminum hydroxide gel oral suspension 320 mg/5ml	Preferred	
ANTACIDS - BICARBONATE**		
sodium bicarbonate oral tablet 325 mg, 650 mg	Preferred	
ANTACIDS - CALCIUM SALTS**		
antacid calcium oral tablet chewable 500 mg	Preferred	
antacid extra strength oral tablet chewable 750 mg	Preferred	
antacid oral tablet chewable 750 mg	Preferred	
antacid ultra strength oral tablet chewable 1000 mg	Preferred	
calcium antacid extra strength oral tablet chewable 750 mg	Preferred	
calcium antacid oral tablet chewable 500 mg	Preferred	
calcium carbonate antacid oral suspension 1250 mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
calcium carbonate antacid oral tablet 648 mg	Preferred	
ft antacid extra strength oral tablet chewable 750 mg	Preferred	
ft antacid regular strength oral tablet chewable 500 mg	Preferred	
gnp antacid extra strength oral tablet chewable 750 mg	Preferred	
gnp antacid oral tablet chewable 500 mg	Preferred	
gnp antacid ultra strength oral tablet chewable 1000 mg	Preferred	
hm antacid extra strength oral tablet chewable 750 mg	Preferred	
sm antacid oral tablet chewable 500 mg	Preferred	
sm calcium antacid ex st oral tablet chewable 750 mg	Preferred	
sm calcium antacid oral tablet chewable 500 mg	Preferred	
sm smooth antacid ex st oral tablet chewable 750 mg	Preferred	
smooth antacid extra strength oral tablet chewable 750 mg	Preferred	
CAL-GEST ANTACID ORAL TABLET CHEWABLE 500 MG (*calcium carbonate antacid*)	Preferred	
ANTACIDS - MAGNESIUM SALTS**		
magnesium oxide oral tablet 400 mg, 420 mg	Preferred	
ANTHELMINTICS**		
albendazole oral tablet 200 mg	Preferred	PA (Eligible for auto-PA approval); QL (4 EA per 1 day)
ivermectin oral tablet 3 mg	Preferred	
ANTIADRENERGICS - PERIPHERALLY ACTING**		
doxazosin mesylate oral tablet 1 mg, 2 mg, 4 mg, 8 mg	Preferred	90-day fill allowed after two 1-month fills
prazosin hcl oral capsule 1 mg, 2 mg, 5 mg	Preferred	
terazosin hcl oral capsule 1 mg, 10 mg, 2 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
ANTIANDROGENS**		
bicalutamide oral tablet 50 mg	Preferred	
ANTIANGINALS-OTHER**		
ranolazine er oral tablet extended release 12 hour 1000 mg, 500 mg	Preferred	QL (2 EA per 1 day)
ANTIANXIETY AGENTS - MISC.**		
buspirone hcl oral tablet 10 mg, 15 mg, 5 mg	Preferred	
hydroxyzine hcl oral syrup 10 mg/5ml	Preferred	AGE (Min 2 Years)
hydroxyzine hcl oral tablet 10 mg, 25 mg, 50 mg	Preferred	AGE (Min 2 Years)
hydroxyzine pamoate oral capsule 100 mg	Preferred	
hydroxyzine pamoate oral capsule 25 mg, 50 mg	Preferred	AGE (Min 2 Years)
ANTIARRHYTHMICS TYPE I-B**		
lidocaine hcl (cardiac) pf intravenous solution 100 mg/5ml	Preferred	
ANTIARRHYTHMICS TYPE I-C**		
flecainide acetate oral tablet 100 mg, 150 mg, 50 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
propafenone hcl oral tablet 150 mg, 225 mg, 300 mg	Preferred	
ANTIARRHYTHMICS TYPE III**		
amiodarone hcl oral tablet 100 mg, 200 mg, 400 mg	Preferred	
amiodarone hcl (Pacerone Oral Tablet 100 Mg, 200 Mg, 400 Mg)	Preferred	
ANTIBIOTIC MIXTURES TOPICAL**		
double antibiotic external ointment 500-10000 unit/gm	Preferred	
ft antibiotic + pain relief external cream 3.5-10000-10	Preferred	
ft double antibiotic external ointment 500-10000 unit/gm	Preferred	
ft triple antibiotic + pain external ointment 1 %	Preferred	
ft triple antibiotic external ointment 3.5-400-5000	Preferred	
gnp antibiotic/pain relief external cream 3.5-10000-10	Preferred	
gnp triple antibiotic external ointment	Preferred	
gnp triple antibiotic plus external ointment 1 %	Preferred	
goodsense first aid antibiotic external ointment	Preferred	
poly bacitracin external ointment 500-10000 unit/gm	Preferred	
sm antibiotic plus pain relief external cream 3.5-10000-10	Preferred	
sm double antibiotic external ointment 500-10000 unit/gm	Preferred	
sm triple antibiotic external ointment 3.5-400-5000	Preferred	
sm triple antibiotic max st external ointment 1 %	Preferred	
sm triple antibiotic original external ointment 3.5-400-5000	Preferred	
triple antibiotic external ointment , 3.5-400-5000 , 5-400-5000	Preferred	
triple antibiotic plus external ointment 1 %	Preferred	
triple antibiotic+pain relief external ointment 1 %	Preferred	
ANTIBIOTICS - TOPICAL**		
bacitracin external ointment 500 unit/gm	Preferred	
bacitracin zinc external ointment 500 unit/gm	Preferred	
bacitracin zinc-aloe external ointment 500 unit/gm	Preferred	
ft antibiotic external ointment 500 unit/gm	Preferred	
gentamicin sulfate external cream 0.1 %	Preferred	
gentamicin sulfate external ointment 0.1 %	Preferred	
gnp bacitracin zinc external ointment 500 unit/gm	Preferred	
sm antibiotic external ointment 500 unit/gm	Preferred	
ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.**		
acidophilus lactobacillus oral capsule	Preferred	
acidophilus-bacillus coagulans oral tablet	Preferred	
bismuth subsalicylate oral tablet chewable 262 mg	Preferred	
ft stomach relief oral suspension 525 mg/30ml	Preferred	
ft stomach relief oral tablet 262 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
ft stomach relief oral tablet chewable 262 mg	Preferred	
gnp pink bismuth oral tablet 262 mg	Preferred	
gnp pink bismuth oral tablet chewable 262 mg	Preferred	
gnp pink bismuth ultra str oral suspension 525 mg/15ml	Preferred	
gnp stomach relief oral suspension 525 mg/30ml	Preferred	
lactobacillus oral packet	Preferred	
lactobacillus oral tablet	Preferred	
quad-probiotic oral capsule	Preferred	
saccharomyces boulardii oral capsule 250 mg	Preferred	
sm acidophilus oral capsule 10 mg	Preferred	
sm stomach relief oral suspension 262 mg/15ml	Preferred	
sm stomach relief oral tablet 262 mg	Preferred	
sm stomach relief oral tablet chewable 262 mg	Preferred	
stomach relief extra strength oral suspension 525 mg/15ml	Preferred	
stomach relief oral suspension 525 mg/30ml	Preferred	
stomach relief oral tablet 262 mg	Preferred	
stomach relief oral tablet chewable 262 mg	Preferred	
stomach relief ultra oral suspension 525 mg/15ml	Preferred	
BOLSITOL ORAL CAPSULE (*lactobacillus*)	Preferred	
DERMACINRX PROBISOL ORAL CAPSULE (*probiotic product*)	Preferred	
DERMACINRX PROBITRAN ORAL CAPSULE (*probiotic product*)	Preferred	
ENVIVE ORAL CAPSULE (*probiotic product*)	Preferred	
FLORANEX ORAL PACKET (*lactobacillus*)	Preferred	
FLORANEX ORAL TABLET (*lactobacillus*)	Preferred	
LACTEROL ORAL CAPSULE (*probiotic product*)	Preferred	
MICROFLOR 33 ORAL CAPSULE (*probiotic product*)	Preferred	
PROBINATE ORAL CAPSULE (*probiotic product*)	Preferred	
PROBITROL ORAL CAPSULE (*probiotic product*)	Preferred	
PROMEROL ORAL CAPSULE (*probiotic product*)	Preferred	
PROVELLA ORAL TABLET (*probiotic product*)	Preferred	
RISA-BID PROBIOTIC ORAL TABLET (*probiotic product*)	Preferred	
RISAQUAD ORAL CAPSULE (*probiotic product*)	Preferred	
RISAQUAD-2 ORAL CAPSULE (*probiotic product*)	Preferred	
ANTIDIARRHEAL/PROBIOTIC COMBINATIONS**		
acidophilus/citrus pectin oral tablet	Preferred	
ANTIDOTES - CHELATING AGENTS**		
deferasirox granules oral packet 180 mg, 360 mg	Preferred	PA
deferasirox oral packet 180 mg, 360 mg	Preferred	PA
deferasirox oral tablet 180 mg, 360 mg, 90 mg	Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
ANTIDOTES AND SPECIFIC ANTAGONISTS**		
potassium iodide (antidote) oral solution 65 mg/ml	Preferred	
ANTIEMETIC COMBINATIONS**		
anti-nausea oral solution 1.87-1.87-21.5	Preferred	
gnp anti-nausea relief oral solution 1.87-1.87-21.5	Preferred	
gnp nausea relief oral solution 1.87-1.87-21.5	Preferred	
goodsense nausea relief oral solution 1.87-1.87-21.5	Preferred	
nausea relief oral solution 1.87-1.87-21.5	Preferred	
ANTIESTROGENS**		
tamoxifen citrate oral tablet 10 mg, 20 mg	Preferred	
ANTIFLATULENTS**		
ft gas relief extra strength oral capsule 125 mg	Preferred	
ft gas relief extra strength oral tablet chewable 125 mg	Preferred	
ft gas relief infants oral suspension 20 mg/0.3ml	Preferred	
ft gas relief oral tablet chewable 80 mg	Preferred	
ft gas relief ultra strength oral capsule 180 mg	Preferred	
gas relief extra strength oral capsule 125 mg	Preferred	
gas relief extra strength oral tablet chewable 125 mg	Preferred	
gas relief infants oral suspension 20 mg/0.3ml	Preferred	
gas relief oral tablet chewable 80 mg	Preferred	
gas relief ultra strength oral capsule 180 mg	Preferred	
gnp anti-gas oral capsule 180 mg	Preferred	
gnp gas relief extra strength oral capsule 125 mg	Preferred	
gnp gas relief extra strength oral tablet chewable 125 mg	Preferred	
gnp gas relief oral tablet chewable 80 mg	Preferred	
gnp infant gas relief oral suspension 20 mg/0.3ml	Preferred	
goodsense gas relief extra st oral capsule 125 mg	Preferred	
simethicone drops infants oral suspension 20 mg/0.3ml	Preferred	
simethicone oral suspension 40 mg/0.6ml	Preferred	
simethicone oral tablet chewable 80 mg	Preferred	
simethicone ultra strength oral capsule 180 mg	Preferred	
sm gas relief extra strength oral capsule 125 mg	Preferred	
sm gas relief infants drops oral suspension 40 mg/0.6ml	Preferred	
sm gas relief infants oral suspension 20 mg/0.3ml	Preferred	
sm gas relief oral capsule 180 mg	Preferred	
sm gas relief oral tablet chewable 125 mg, 80 mg	Preferred	
ANTIHISTAMINE HYPNOTIC COMBINATIONS**		
acetaminophen pm oral tablet 500-25 mg	Preferred	
ft pain reliever pm extra str oral tablet 25-500 mg	Preferred	
gnp pain relief es night time oral tablet 25-500 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
gnp pain relief pm ex st oral tablet 25-500 mg	Preferred	
goodsense pain relief pm ex st oral tablet 25-500 mg	Preferred	
sm headache relief pm oral tablet 500-38 mg	Preferred	
ANTIHISTAMINE HYPNOTICS**		
ft nighttime sleep aid oral tablet 25 mg	Preferred	
gnp sleep aid nighttime oral tablet 25 mg	Preferred	
nighttime sleep aid oral tablet 25 mg	Preferred	
sleep aid (diphenhydramine) oral tablet 25 mg	Preferred	
sleep tabs oral tablet 25 mg	Preferred	
ANTIHISTAMINES - ALKYLAMINES**		
aller-chlor oral tablet 4 mg	Preferred	
allergy oral tablet 4 mg	Preferred	
allergy relief oral tablet 4 mg	Preferred	
chlorpheniramine maleate er oral tablet extended release 12 mg	Preferred	
ed chlorped jr oral syrup 2 mg/5ml	Preferred	
ft allergy relief oral tablet 4 mg	Preferred	
gnp allergy relief oral tablet 4 mg	Preferred	
triprolidine hcl oral liquid 0.625 mg/ml, 0.938 mg/ml	Preferred	
ALA-HIST IR ORAL TABLET 2 MG (*dexbrompheniramine maleate*)	Preferred	
HISTEX ORAL SYRUP 2.5 MG/5ML (*triprolidine hcl*)	Preferred	
HISTEX PD ORAL LIQUID 0.938 MG/ML (*triprolidine hcl*)	Preferred	
ANTIHISTAMINES - ETHANOLAMINES**		
allergy oral capsule 25 mg	Preferred	
allergy relief childrens oral liquid 12.5 mg/5ml	Preferred	
allergy relief oral capsule 25 mg	Preferred	
allergy relief oral tablet 25 mg	Preferred	
carbinoxamine maleate oral solution 4 mg/5ml	Preferred	AGE (Min 2 Years)
carbinoxamine maleate oral tablet 4 mg	Preferred	AGE (Min 2 Years)
clemastine fumarate oral tablet 2.68 mg	Preferred	AGE (Min 2 Years)
diphenhydramine hcl childrens oral liquid 12.5 mg/5ml	Preferred	
diphenhydramine hcl injection solution 50 mg/ml	Preferred	
diphenhydramine hcl oral capsule 25 mg, 50 mg	Preferred	
diphenhydramine hcl oral elixir 12.5 mg/5ml	Preferred	
diphenhydramine hcl oral liquid 12.5 mg/5ml, 25 mg/10ml	Preferred	
diphenhydramine hcl oral tablet 25 mg	Preferred	
ft allergy relief childrens oral liquid 12.5 mg/5ml	Preferred	
ft allergy relief oral capsule 25 mg	Preferred	
ft allergy relief oral tablet 25 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
gnp allergy oral capsule 25 mg	Preferred	
gnp allergy oral tablet 25 mg	Preferred	
gnp allergy relief max st oral liquid 12.5 mg/5ml	Preferred	
gnp allergy relief oral capsule 25 mg	Preferred	
gnp allergy relief oral tablet 25 mg	Preferred	
gnp allergy relief oral tablet chewable 12.5 mg	Preferred	
gnp childrens allergy oral liquid 12.5 mg/5ml	Preferred	
liquid allergy relief oral liquid 12.5 mg/5ml	Preferred	
m-dryl oral liquid 12.5 mg/5ml	Preferred	
siladryl allergy oral liquid 12.5 mg/5ml	Preferred	
sm allergy relief childrens oral liquid 12.5 mg/5ml	Preferred	
sm allergy relief oral tablet 25 mg	Preferred	
BANOPHEN ORAL CAPSULE 25 MG, 50 MG (*diphenhydramine hcl*)	Preferred	
BANOPHEN ORAL TABLET 25 MG (*diphenhydramine hcl*)	Preferred	
ANTIHISTAMINES - PIPERIDINES**		
cyproheptadine hcl oral syrup 2 mg/5ml	Preferred	AGE (Min 2 Years)
cyproheptadine hcl oral tablet 4 mg	Preferred	AGE (Min 2 Years)
ANTIHISTAMINE-TOPICAL COMBINATIONS**		
anti-itch external cream 2-0.1 %	Preferred	
diphenhydramine-zinc acetate external cream 2-0.1 %	Preferred	
ft anti-itch extra strength external cream 2-0.1 %	Preferred	
gnp anti-itch external cream 2-0.1 %	Preferred	
itch relief extra strength external cream 2-0.1 %	Preferred	
sm anti-itch extra strength external cream 2-0.1 %	Preferred	
BANOPHEN EXTERNAL CREAM 2-0.1 % (*diphenhydramine-zinc acetate*)	Preferred	
ANTI-INFECTIVE AGENTS - MISC.**		
trimethoprim oral tablet 100 mg	Preferred	
ANTI-INFECTIVE MISC. - COMBINATIONS**		
sulfamethoxazole-trimethoprim oral suspension 200-40 mg/5ml, 800-160 mg/20ml	Preferred	90-day fill allowed after two 1-month fills
sulfamethoxazole-trimethoprim oral tablet 400-80 mg, 800-160 mg	Preferred	90-day fill allowed after two 1-month fills
sulfamethoxazole-trimethoprim (Sulfatrim Pediatric Oral Suspension 200-40 Mg/5Ml)	Preferred	90-day fill allowed after two 1-month fills
ANTIMALARIAL COMBINATIONS**		
atovaquone-proguanil hcl oral tablet 250-100 mg, 62.5-25 mg	Preferred	
ANTIMALARIALS**		
chloroquine phosphate oral tablet 250 mg, 500 mg	Preferred	PA
hydroxychloroquine sulfate oral tablet 200 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
mefloquine hcl oral tablet 250 mg	Preferred	
quinine sulfate oral capsule 324 mg	Preferred	QL (42 EA per 365 days)
SOVUNA ORAL TABLET 200 MG (*hydroxychloroquine sulfate*)	Preferred	
ANTIMANIC AGENTS**		
lithium carbonate er oral tablet extended release 300 mg, 450 mg	Preferred	90-day fill allowed after two 1-month fills
lithium carbonate oral capsule 150 mg, 300 mg, 600 mg	Preferred	90-day fill allowed after two 1-month fills
lithium carbonate oral tablet 300 mg	Preferred	90-day fill allowed after two 1-month fills
ANTIMETABOLITES**		
capecitabine oral tablet 150 mg, 500 mg	Preferred	SP; PA
mercaptopurine oral tablet 50 mg	Preferred	
ANTIMYASTHENIC/CHOLINERGIC AGENTS**		
pyridostigmine bromide oral solution 60 mg/5ml	Preferred	
pyridostigmine bromide oral tablet 60 mg	Preferred	
ANTIMYCOBACTERIAL AGENTS**		
ethambutol hcl oral tablet 100 mg, 400 mg	Preferred	
isoniazid oral syrup 50 mg/5ml	Preferred	
isoniazid oral tablet 100 mg, 300 mg	Preferred	
rifabutin oral capsule 150 mg	Preferred	PA
rifampin oral capsule 150 mg, 300 mg	Preferred	
ANTINEOPLASTIC - BCR-ABL KINASE INHIBITORS**		
imatinib mesylate oral tablet 100 mg	Preferred	SP; PA; QL (8 EA per 1 day)
imatinib mesylate oral tablet 400 mg	Preferred	SP; PA; QL (2 EA per 1 day)
ANTINEOPLASTIC - MULTIKINASE INHIBITORS**		
sunitinib malate oral capsule 12.5 mg	Preferred	SP; PA; QL (7 EA per 1 day)
sunitinib malate oral capsule 25 mg	Preferred	SP; PA; QL (3 EA per 1 day)
sunitinib malate oral capsule 37.5 mg, 50 mg	Preferred	SP; PA; QL (1 EA per 1 day)
ANTINEOPLASTIC ANTIMETABOLITES - TOPICAL**		
fluorouracil external cream 5 %	Preferred	
fluorouracil external solution 5 %	Preferred	
ANTINEOPLASTIC OR PREMALIGNANT LESIONS - TOPICAL NSAID'S**		
diclofenac sodium external gel 3 %	Preferred	PA; QL (3.334 GM per 1 day)
ANTINEOPLASTICS MISC.**		
hydroxyurea oral capsule 500 mg	Preferred	
ANTIPARKINSON ANTICHOLINERGICS**		
benztropine mesylate oral tablet 0.5 mg, 1 mg, 2 mg	Preferred	90-day fill allowed after two 1-month fills
trihexyphenidyl hcl oral solution 0.4 mg/ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
trihexyphenidyl hcl oral tablet 2 mg, 5 mg	Preferred	
ANTIPARKINSON DOPAMINERGICS**		
amantadine hcl oral capsule 100 mg	Preferred	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS**		
selegiline hcl oral capsule 5 mg	Preferred	
selegiline hcl oral tablet 5 mg	Preferred	
ANTIPERISTALTIC AGENTS**		
anti-diarrheal oral solution 1 mg/7.5ml	Preferred	
anti-diarrheal oral tablet 2 mg	Preferred	
diphenoxylate-atropine oral liquid 2.5-0.025 mg/5ml	Preferred	
diphenoxylate-atropine oral tablet 2.5-0.025 mg	Preferred	
ft anti-diarrheal oral capsule 2 mg	Preferred	
ft anti-diarrheal oral solution 1 mg/7.5ml	Preferred	
ft anti-diarrheal oral tablet 2 mg	Preferred	
gnp anti-diarrheal oral capsule 2 mg	Preferred	
gnp anti-diarrheal oral tablet 2 mg	Preferred	
gnp loperamide hcl oral solution 1 mg/7.5ml	Preferred	
goodsense anti-diarrheal oral solution 1 mg/7.5ml	Preferred	
hm anti-diarrheal oral solution 1 mg/7.5ml	Preferred	
loperamide hcl oral capsule 2 mg	Preferred	
loperamide hcl oral solution 1 mg/7.5ml	Preferred	
loperamide hcl oral tablet 2 mg	Preferred	
sm anti-diarrheal oral capsule 2 mg	Preferred	
sm anti-diarrheal oral solution 1 mg/7.5ml	Preferred	
sm anti-diarrheal oral tablet 2 mg	Preferred	
ANTIPROTOZOAL AGENTS**		
atovaquone oral suspension 750 mg/5ml	Preferred	PA
ANTISEBORRHEIC PRODUCTS**		
anti-dandruff external shampoo 1 %	Preferred	
dandruff shampoo external lotion 1 %	Preferred	
selenium sulfide external lotion 2.5 %	Preferred	
selenium sulfide external shampoo 2.25 %	Preferred	
ANTISEPTICS - MOUTH/THROAT**		
chlorhexidine gluconate mouth/throat solution 0.12 %	Preferred	
gnp sore throat spray mouth/throat liquid 1.4 %	Preferred	
phenaseptic mouth/throat liquid 1.4 %	Preferred	
sm sore throat spray mouth/throat liquid 1.4 %	Preferred	
sore throat mouth/throat liquid 1.4 %	Preferred	
sore throat spray mouth/throat liquid 1.4 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
ANTISPASMODICS**		
dicyclomine hcl oral capsule 10 mg	Preferred	
dicyclomine hcl oral solution 10 mg/5ml	Preferred	
dicyclomine hcl oral tablet 20 mg	Preferred	
ANTITHYROID AGENTS**		
methimazole oral tablet 10 mg, 5 mg	Preferred	
propylthiouracil oral tablet 50 mg	Preferred	
ANTITUSSIVE - NONNARCOTIC**		
benzonatate oral capsule 100 mg	Preferred	QL (6 EA per 1 day); AGE (Min 6 Years)
benzonatate oral capsule 200 mg	Preferred	QL (3 EA per 1 day)
cough dm childrens oral suspension extended release 30 mg/5ml	Preferred	
cough dm oral suspension extended release 30 mg/5ml	Preferred	
dextromethorphan hbr oral capsule 15 mg	Preferred	
dextromethorphan polistirex er oral suspension extended release 30 mg/5ml	Preferred	
ft 12 hour cough relief oral suspension extended release 30 mg/5ml	Preferred	
gnp cough dm er oral suspension extended release 30 mg/5ml	Preferred	
gnp tussin cough long acting oral syrup 15 mg/5ml	Preferred	
goodsense cough dm childrens oral suspension extended release 30 mg/5ml	Preferred	
goodsense cough dm oral suspension extended release 30 mg/5ml	Preferred	
hm cough dm oral suspension extended release 30 mg/5ml	Preferred	
sm cough relief oral syrup 15 mg/5ml	Preferred	
ANTITUSSIVE-ANTIHISTAMINE-ANALGESIC**		
all-nite cold & flu nighttime oral liquid 30-12.5-650 mg/30ml	Preferred	
cold & flu nighttime relief oral capsule 15-6.25-325 mg	Preferred	
cold & flu relief nighttime oral capsule 15-6.25-325 mg	Preferred	
ft nighttime cold & flu oral liquid 15-6.25-325 mg/15ml	Preferred	
gnp night time cold & flu oral liquid 15-6.25-325 mg/15ml	Preferred	
gnp night time cold-flu oral capsule 15-6.25-325 mg	Preferred	
goodsense nighttime cold & flu oral capsule 15-6.25-325 mg	Preferred	
nighttime cold/flu relief oral liquid 15-6.25-325 mg/15ml	Preferred	
sm cough/sore throat nighttime oral liquid 30-12.5-1000 mg/30ml	Preferred	
sm nite time cold & flu oral liquid 15-6.25-325 mg/15ml	Preferred	
ANTITUSSIVE-DECONGESTANT-ANALGESIC**		
cold & flu relief daytime oral capsule 10-5-325 mg	Preferred	
cold/flu daytime relief oral capsule 10-5-325 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
daytime cold & flu relief oral liquid 10-5-325 mg/15ml	Preferred	
flu/severe cold & cough day oral packet 20-10-650 mg	Preferred	
ft daytime cold & flu relief oral liquid 10-5-325 mg/15ml	Preferred	
gnp cold max daytime oral tablet 10-5-325 mg	Preferred	
gnp day time cold/flu oral capsule 10-5-325 mg	Preferred	
goodsense cold & flu oral liquid 10-5-325 mg/15ml	Preferred	
goodsense day time cold & flu oral capsule 10-5-325 mg	Preferred	
sm day time cold & flu relief oral liquid 10-5-325 mg/15ml	Preferred	
MAPAP COLD FORMULA MULTI-SYMPT ORAL TABLET 10-5-325 MG (*dm-phenylephrine-acetaminophen*)	Preferred	
ANTITUSSIVE-EXPECTORANT - DECONGEST-ANALGESIC**		
ft cold & flu daytime severe oral liquid 5-10-200-325 mg/15ml	Preferred	
ft cold & flu daytime severe oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
gnp cold/flu severe oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
goodsense day time cold & flu oral liquid 5-10-200-325 mg/15ml	Preferred	
severe cold & flu oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
sm cold & flu severe oral tablet 5-10-200-325 mg	Preferred	QL (1 EA per 1 day)
sm daytime severe cold & flu oral liquid 5-10-200-325 mg/15ml	Preferred	
tussin cf severe multi-symptom oral liquid 5-10-200-325 mg/10ml	Preferred	
ANTITUSSIVE-EXPECTORANT**		
chest congestion relief dm oral syrup 10-100 mg/5ml	Preferred	
chest congestion relief dm oral tablet 20-400 mg	Preferred	
dextromethorphan-guaifenesin oral liquid 10-100 mg/5ml, 5-100 mg/5ml	Preferred	
dextromethorphan-guaifenesin oral syrup 10-100 mg/5ml, 20-200 mg/10ml	Preferred	
dm-guaifenesin er oral tablet extended release 12 hour 60-1200 mg	Preferred	
ft chest congestion relief dm oral tablet 20-400 mg	Preferred	
ft mucus relief dm oral tablet extended release 12 hour 1200-60 mg, 30-600 mg	Preferred	
ft tussin dm max adult oral liquid 20-400 mg/20ml	Preferred	
gnp mucus dm max strength oral tablet extended release 12 hour 60-1200 mg	Preferred	
gnp mucus relief dm oral tablet 20-400 mg	Preferred	
gnp tab tussin dm oral tablet 20-400 mg	Preferred	
gnp tussin dm cough oral liquid 100-10 mg/5ml	Preferred	
gnp tussin dm max oral liquid 20-400 mg/20ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
goodsense mucus dm oral tablet extended release 12 hour 60-1200 mg	Preferred	
goodsense tussin dm max oral liquid 20-400 mg/20ml	Preferred	
guaifenesin-dm oral syrup 100-10 mg/5ml	Preferred	
mucus relief cough childrens oral liquid 5-100 mg/5ml	Preferred	
mucus relief dm cough oral tablet 20-400 mg	Preferred	
mucus relief dm max oral liquid 20-400 mg/20ml	Preferred	
mucus relief dm max oral tablet extended release 12 hour 60-1200 mg	Preferred	
mucus relief dm oral liquid 20-400 mg/20ml	Preferred	
mucus relief dm oral tablet extended release 12 hour 30-600 mg	Preferred	
mucus-dm maximum strength oral tablet extended release 12 hour 60-1200 mg	Preferred	
sm chest congestion relief dm oral tablet 20-400 mg	Preferred	
sm tussin dm max oral liquid 20-400 mg/20ml	Preferred	
sm tussin dm oral syrup 100-10 mg/5ml	Preferred	
tusnel diabetic oral liquid 10-100 mg/5ml	Preferred	
tussin dm cough + chest oral liquid 10-100 mg/5ml, 20-400 mg/20ml	Preferred	
tussin dm oral liquid 100-10 mg/5ml	Preferred	
tussin dm oral syrup 100-10 mg/5ml	Preferred	
ANTITUSSIVE-EXPECTORANTS-DECONGESTANT**		
capmist dm oral tablet 60-15-400 mg	Preferred	
ft tussin cf adult oral liquid 10-20-200 mg/10ml	Preferred	
gnp tussin cf cough & cold oral syrup 5-10-100 mg/5ml	Preferred	
goodsense mucus relief child oral liquid 2.5-5-100 mg/5ml	Preferred	
goodsense tussin cf oral liquid 5-10-100 mg/5ml	Preferred	
multi-symptom cold childrens oral liquid 2.5-5-100 mg/5ml	Preferred	
robafen cf multi-symptom cold oral liquid 5-10-100 mg/5ml	Preferred	
sm mucus relief cold childrens oral liquid 2.5-5-100 mg/5ml	Preferred	
sm severe congestion & cough oral liquid 10-20-400 mg/20ml	Preferred	
sm tussin cf oral liquid 5-10-100 mg/5ml	Preferred	
tussin multi-symptom cold cf oral liquid 5-10-100 mg/5ml	Preferred	
TUSNEL ORAL LIQUID 30-15-200 MG/5ML (*pseudoephedrine-dm-gg*)	Preferred	
TUSNEL PEDIATRIC ORAL LIQUID 15-5-50 MG/5ML (*pseudoephedrine-dm-gg*)	Preferred	
ANTIVIRAL COMBINATIONS**		
PAXLOVID (150/100) ORAL TABLET THERAPY PACK 10 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	Preferred	Max 5-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
PAXLOVID (300/100) ORAL TABLET THERAPY PACK 20 X 150 MG & 10 X 100MG (*nirmatrelvir-ritonavir*)	Preferred	Max 5-day supply per 1 Fill
ANTIVIRAL MONOCLONAL ANTIBODIES**		
SYNAGIS INTRAMUSCULAR SOLUTION 100 MG/ML, 50 MG/0.5ML (*palivizumab*)	Preferred	SP; PA
APPLICATORS,COTTON BALLS,ETC**		
alcohol pads pad 70 %	Preferred	Max 100-day supply per 1 Fill
alcohol prep pad , 70 %	Preferred	Max 100-day supply per 1 Fill
alcohol prep pads pad 70 %	Preferred	Max 100-day supply per 1 Fill
alcohol swabs pad , 70 %	Preferred	Max 100-day supply per 1 Fill
alcoh-wipe sheet	Preferred	
aum alcohol prep pads pad 70 %	Preferred	Max 100-day supply per 1 Fill
cvs alcohol prep pads pad 70 %	Preferred	Max 100-day supply per 1 Fill
cvs prep pad 70 %	Preferred	Max 100-day supply per 1 Fill
easy comfort alcohol pads pad	Preferred	Max 100-day supply per 1 Fill
eql alcohol swabs pad 70 %	Preferred	Max 100-day supply per 1 Fill
essentra wipes 9x9" sheet 70 %	Preferred	
global alcohol prep ease pad 70 %	Preferred	Max 100-day supply per 1 Fill
gnp alcohol swabs pad 70 %	Preferred	Max 100-day supply per 1 Fill
h-e-b incontrol alcohol pad	Preferred	Max 100-day supply per 1 Fill
hm sterile alcohol prep pad	Preferred	Max 100-day supply per 1 Fill
meijer alcohol swabs pad 70 %	Preferred	Max 100-day supply per 1 Fill
pro comfort alcohol pad 70 %	Preferred	Max 100-day supply per 1 Fill
pure comfort alcohol prep pad	Preferred	Max 100-day supply per 1 Fill
qc alcohol swabs pad 70 %	Preferred	Max 100-day supply per 1 Fill
ra alcohol swabs pad 70 %	Preferred	Max 100-day supply per 1 Fill
reality swabs pad	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
saps care alcohol prep pad 70 %	Preferred	Max 100-day supply per 1 Fill
saps health alcohol prep pad , 70 %	Preferred	Max 100-day supply per 1 Fill
saps health care alcohol prep pad 70 %	Preferred	Max 100-day supply per 1 Fill
sb alcohol prep pad 70 %	Preferred	Max 100-day supply per 1 Fill
sm alcohol prep pad , 70 %	Preferred	Max 100-day supply per 1 Fill
sure comfort alcohol prep pad 70 %	Preferred	Max 100-day supply per 1 Fill
true comfort alcohol prep pads pad 70 %	Preferred	Max 100-day supply per 1 Fill
true comfort pro alcohol prep pad 70 %	Preferred	Max 100-day supply per 1 Fill
ultilet alcohol swabs pad	Preferred	Max 100-day supply per 1 Fill
ultra-care alcohol prep pads pad 70 %	Preferred	Max 100-day supply per 1 Fill
zevrx sterile alcohol prep pad pad 70 %	Preferred	Max 100-day supply per 1 Fill
ADVOCATE ALCOHOL PREP PADS PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
ALCOH-GLOVE CONTOURED WIPE PAD (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
ALCOHOL SWABSTICK PAD (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
BD SWAB SINGLE USE REGULAR PAD (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH ALCOHOL PREP PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH ALCOHOL PREP PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
CURITY ALCOHOL PREPS PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
DROPSAFE ALCOHOL PREP PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH ALCOHOL PREP MEDIUM PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
FIFTY50 ALCOHOL PREP PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
PHARMACIST CHOICE ALCOHOL PAD (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
RELION ALCOHOL SWABS PAD , 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
ULTICARE ALCOHOL SWABS PAD , 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
WEBCOL ALCOHOL PREP LARGE PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
WEBCOL ALCOHOL PREP MEDIUM PAD 70 % (*alcohol swabs*)	Preferred	Max 100-day supply per 1 Fill
AROMATASE INHIBITORS**		
anastrozole oral tablet 1 mg	Preferred	
letrozole oral tablet 2.5 mg	Preferred	
ARTIFICIAL TEAR AND LUBRICANT COMBINATIONS**		
artificial tears ophthalmic solution 0.5-0.6 %	Preferred	
dry eye relief drops ophthalmic solution 0.2-0.2-1 %	Preferred	
ft lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
gnp artificial tears ophthalmic solution 5-6 mg/ml	Preferred	
gnp eye drops long lasting ophthalmic solution 0.4-0.3 %	Preferred	
gnp eye drops ophthalmic solution 0.2-0.2-1 %	Preferred	
gnp nighttime relief lub eye ophthalmic ointment 57.3-42.5 %	Preferred	
lubricant eye drops (pf) ophthalmic solution 0.4-0.3 %	Preferred	
lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
lubricant eye nighttime ophthalmic ointment	Preferred	
lubricating eye drops ophthalmic solution 0.4-0.3 %	Preferred	
lubrifresh p.m. ophthalmic ointment	Preferred	
sm dry eye relief ophthalmic solution 0.2-0.2-1 %	Preferred	
sm lubricant eye drops ophthalmic solution 0.4-0.3 %	Preferred	
sm lubricating tears ophthalmic solution 0.4-0.3 %	Preferred	
ultra lubricating eye drops ophthalmic solution 0.4-0.3 %	Preferred	
ultra lubricating eye drops pf ophthalmic solution 0.4-0.3 %	Preferred	
BION TEARS PF OPHTHALMIC SOLUTION 0.1-0.3 % (*dextran 70-hypromellose*)	Preferred	
GENTEAL TEARS NIGHT-TIME OPHTHALMIC OINTMENT (*white petrolatum-mineral oil*)	Preferred	
GENTEAL TEARS SEVERE DAY/NIGHT OPHTHALMIC GEL 0.4-0.3 % (*polyethyl glycol-propyl glycol*)	Preferred	
REFRESH DIGITAL OPHTHALMIC SOLUTION 0.5-1-0.5 % (*carboxymeth-glycerin-polysorb*)	Preferred	
REFRESH DIGITAL PF OPHTHALMIC SOLUTION 0.5-1-0.5 % (*carboxymeth-glycerin-polysorb*)	Preferred	
REFRESH LACRI-LUBE OPHTHALMIC OINTMENT (*white petrolatum-mineral oil*)	Preferred	
REFRESH OPHTHALMIC SOLUTION 1.4-0.6 % (*polyvinyl alcohol-povidone*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
REFRESH OPTIVE ADVANCED OPHTHALMIC SOLUTION 0.5-1-0.5 % (*carboxymeth-glycerin-polysorb*)	Preferred	
REFRESH OPTIVE ADVANCED PF OPHTHALMIC SOLUTION 0.5-1-0.5 % (*carboxymeth-glycerin-polysorb*)	Preferred	
REFRESH OPTIVE MEGA-3 OPHTHALMIC SOLUTION 0.5-1-0.5 % (*carboxymeth-glycerin-polysorb*)	Preferred	
REFRESH OPTIVE OPHTHALMIC GEL 1-0.9 % (*carboxymethylcellul-glycerin*)	Preferred	
REFRESH OPTIVE PF OPHTHALMIC SOLUTION 0.5-0.9 % (*carboxymethylcellul-glycerin*)	Preferred	
REFRESH P.M. OPHTHALMIC OINTMENT (*white petrolatum-mineral oil*)	Preferred	
REFRESH RELIEVA PF OPHTHALMIC SOLUTION 0.5-0.9 % (*carboxymethylcellul-glycerin*)	Preferred	
REFRESH TEARS PF OPHTHALMIC SOLUTION 0.5-0.9 % (*carboxymethylcellul-glycerin*)	Preferred	
SYSTANE NIGHTTIME OPHTHALMIC OINTMENT (*white petrolatum-mineral oil*)	Preferred	
SYSTANE OPHTHALMIC GEL 0.4-0.3 % (*polyethyl glycol-propyl glycol*)	Preferred	
ARTIFICIAL TEAR SOLUTIONS**		
artificial tears ophthalmic solution	Preferred	
sm artificial tears ophthalmic solution	Preferred	
GENTEAL TEARS OPHTHALMIC SOLUTION 0.1-0.2-0.3 % (*artificial tear solution*)	Preferred	
SYSTANE CONTACTS OPHTHALMIC SOLUTION (*artificial tear solution*)	Preferred	
ARTIFICIAL TEARS AND LUBRICANTS**		
carboxymethylcellulose sodium ophthalmic solution 0.5 %	Preferred	
ft lubricant eye drops ophthalmic solution 0.5 %	Preferred	
gnp lubricant eye drops (pf) ophthalmic solution 0.5 %	Preferred	
gnp lubricating plus eye drops ophthalmic solution 0.5 %	Preferred	
goodsense lubricating eye drop ophthalmic solution 0.5 %	Preferred	
lubricant eye drops ophthalmic solution 0.6 %	Preferred	
lubricant eye drops pf ophthalmic solution 0.5 %	Preferred	
polyvinyl alcohol ophthalmic solution 1.4 %	Preferred	
sentia ophthalmic solution 0.6 %	Preferred	
sm lubricating plus ophthalmic solution 0.5 %	Preferred	
ventiva tears ophthalmic solution 0.5 %	Preferred	
ALCON TEARS OPHTHALMIC SOLUTION 0.5 % (*hypromellose*)	Preferred	
GENTEAL SEVERE OPHTHALMIC GEL 0.3 % (*hypromellose*)	Preferred	
REFRESH CELLUVISC OPHTHALMIC GEL 1 % (*carboxymethylcellulose sodium*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
ASTRINGENTS**		
diaper rash external ointment 40 %	Preferred	
gnp calamine phenolated external lotion	Preferred	
gnp zinc oxide external ointment 20 %	Preferred	
sm calamine phenolated external lotion	Preferred	
sm hygienic cleansing external pad 50 %	Preferred	
zinc oxide external ointment 20 %	Preferred	
B-COMPLEX VITAMINS**		
b-complex/b-12 oral tablet	Preferred	
vitamin b complex oral capsule	Preferred	
vitamin b complex w/b-12 oral tablet	Preferred	
B-COMPLEX W/ C & FOLIC ACID**		
folbee plus oral tablet	Preferred	
folika-bc oral tablet 1 mg	Preferred	
tm-vite rx oral tablet 1 mg	Preferred	
triphrocaps oral capsule 1 mg	Preferred	
wescaps oral capsule 1 mg	Preferred	
DIALYVITE 800 ORAL TABLET 0.8 MG (*b complex-c-folic acid*)	Preferred	
b complex-c-folic acid (Dialyvite Oral Tablet)	Preferred	
b complex-c-folic acid (Nephronex Oral Tablet)	Preferred	
NEPHRO-VITE ORAL TABLET 0.8 MG (*b complex-c-folic acid*)	Preferred	
B-COMPLEX W/ C**		
sm super b complex/c oral tablet	Preferred	
B-COMPLEX W/ C-ZN & FOLIC ACID**		
DIALYVITE 800/ZINC ORAL TABLET 0.8 MG (*b complex-c-zn-folic acid*)	Preferred	
DIALYVITE 800-ZINC 15 ORAL TABLET 0.8 MG (*b complex-c-zn-folic acid*)	Preferred	
B-COMPLEX W/ MINERALS**		
ELDERTONIC ORAL LIQUID (*b complex-minerals*)	Preferred	
BENZODIAZEPINES**		
alprazolam oral tablet 0.25 mg, 0.5 mg, 1 mg	Preferred	QL (4 EA per 1 day)
alprazolam oral tablet 2 mg	Preferred	QL (5 EA per 1 day)
chlordiazepoxide hcl oral capsule 10 mg	Preferred	QL (30 EA per 1 day)
chlordiazepoxide hcl oral capsule 25 mg	Preferred	QL (12 EA per 1 day)
chlordiazepoxide hcl oral capsule 5 mg	Preferred	QL (4 EA per 1 day)
diazepam oral concentrate 5 mg/ml	Preferred	
diazepam oral solution 5 mg/5ml	Preferred	
diazepam oral tablet 10 mg, 2 mg, 5 mg	Preferred	
lorazepam oral tablet 0.5 mg, 1 mg	Preferred	QL (3 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
lorazepam oral tablet 2 mg	Preferred	QL (5 EA per 1 day)
diazepam (Diazepam Intensol Oral Concentrate 5 Mg/Ml)	Preferred	
BETA ADRENERGICS**		
albuterol sulfate oral syrup 2 mg/5ml	Preferred	
BIPHASIC CONTRACEPTIVES - ORAL**		
desogestrel-ethinyl estradiol oral tablet 0.15-0.02/0.01 mg (21/5)	Preferred	Max 365-day supply per 1 Fill
viorele oral tablet 0.15-0.02/0.01 mg (21/5)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Azurette Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Kariva Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Pimtrea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Simliya Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Volnea Oral Tablet 0.15-0.02/0.01 Mg (21/5))	Preferred	Max 365-day supply per 1 Fill
BOWEL EVACUANT COMBINATIONS**		
peg 3350-kcl-na bicarb-nacl oral solution reconstituted 420 gm	Preferred	
peg-3350/electrolytes oral solution reconstituted 236 gm	Preferred	
peg-3350/electrolytes/ascorbat oral solution reconstituted 100 gm	Preferred	
peg-kcl-nacl-nasulf-na asc-c oral solution reconstituted 100 gm	Preferred	
GAVILYTE-C ORAL SOLUTION RECONSTITUTED 240 GM (*peg 3350-kcl-nabcb-nacl-nasulf*)	Preferred	
peg 3350-kcl-nabcb-nacl-nasulf (Gavilyte-G Oral Solution Reconstituted 236 Gm)	Preferred	
peg 3350-kcl-na bicarb-nacl (Gavilyte-N With Flavor Pack Oral Solution Reconstituted 420 Gm)	Preferred	
BULK LAXATIVES**		
fiber laxative + calcium oral tablet 625 mg	Preferred	
fiber oral tablet 625 mg	Preferred	
fiber-lax oral tablet 625 mg	Preferred	
ft fiber laxative oral tablet 500 mg, 625 mg	Preferred	
gnp fiber oral powder 43 %	Preferred	
gnp fiber therapy oral tablet 500 mg	Preferred	
gnp fiber-caps oral tablet 625 mg	Preferred	
gnp natural fiber oral capsule 0.52 gm	Preferred	
gnp natural fiber oral powder 28.3 %	Preferred	
sm fiber laxative oral tablet 500 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
sm fiber oral powder 28.3 %, 43 %, 58.6 %	Preferred	
sm fiber oral tablet 625 mg	Preferred	
SOLUBLE FIBER THERAPY ORAL POWDER (*methylcellulose (laxative)*)	Preferred	
BURN PRODUCTS**		
silver sulfadiazine external cream 1 %	Preferred	
silver sulfadiazine (Ssd External Cream 1 %)	Preferred	
CALCIMIMETIC AGENTS**		
cinacalcet hcl oral tablet 30 mg, 60 mg, 90 mg	Preferred	PA; QL (2 EA per 1 day)
CALCIUM COMBINATIONS**		
calcium + vitamin d3 oral tablet 500-5 mg-mcg	Preferred	
calcium-vitamin d3 oral tablet 250-3.125 mg-mcg	Preferred	
citrus calcium/vitamin d oral tablet 200-6.25 mg-mcg	Preferred	
gnp calcium citrate +d3 oral tablet 315-6.25 mg-mcg	Preferred	
oyster shell calcium w/d oral tablet 500-5 mg-mcg	Preferred	
oyster shell calcium/vit d oral tablet 500-5 mg-mcg	Preferred	
risacal-d oral tablet 105-81-120 mg-mg-unit	Preferred	
sm calcium 500/vitamin d3 oral tablet 500-10 mg-mcg	Preferred	
sm calcium 600/vitamin d oral tablet 600-10 mg-mcg	Preferred	
sm calcium citrate-vit d oral tablet 315-5 mg-mcg	Preferred	
sm calcium-magnesium-zinc oral tablet 333-133-5 mg	Preferred	
sm oyster shell calcium/vit d oral tablet 500-10 mg-mcg	Preferred	
sm oyster shell calcium/vit d3 oral tablet 500-10 mg-mcg	Preferred	
ultra calcium + vitamin d3 oral tablet 600-10 mg-mcg	Preferred	
MAGNEBIND 300 ORAL TABLET 250-300 MG (*calcium carb-magnesium carb*)	Preferred	
OS-CAL CALCIUM + D3 ORAL TABLET 500-5 MG-MCG (*calcium carb-cholecalciferol*)	Preferred	
OS-CAL EXTRA D3 ORAL TABLET 500-15 MG-MCG (*calcium carb-cholecalciferol*)	Preferred	
OS-CAL ORAL TABLET CHEWABLE 500-15 MG-MCG (*calcium carb-cholecalciferol*)	Preferred	
OYSCO 500+D ORAL TABLET 500-5 MG-MCG (*calcium carb-cholecalciferol*)	Preferred	
CALCIUM**		
gnp calcium oral tablet 1500 (600 ca) mg	Preferred	
oyster shell calcium oral tablet 500 mg	Preferred	
true oyster shell calcium oral tablet 1250 (500 ca) mg	Preferred	
SM CORAL CALCIUM ORAL TABLET 1000 (390 CA) MG (*coral calcium*)	Preferred	
CARBOHYDRATES**		
dextrose intravenous solution 5 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
CARBONIC ANHYDRASE INHIBITORS**		
acetazolamide er oral capsule extended release 12 hour 500 mg	Preferred	
acetazolamide oral tablet 125 mg, 250 mg	Preferred	
CARDIAC GLYCOSIDES**		
digoxin oral solution 0.05 mg/ml	Preferred	90-day fill allowed after two 1-month fills
digoxin oral tablet 125 mcg, 250 mcg	Preferred	90-day fill allowed after two 1-month fills
CEPHALOSPORINS - 1ST GENERATION**		
cefadroxil oral capsule 500 mg	Preferred	
cefadroxil oral suspension reconstituted 500 mg/5ml	Preferred	
cefadroxil oral tablet 1 gm	Preferred	
cephalexin oral capsule 250 mg, 500 mg	Preferred	
cephalexin oral suspension reconstituted 125 mg/5ml, 250 mg/5ml	Preferred	
CHELATING AGENTS**		
penicillamine oral tablet 250 mg	Preferred	PA; QL (4 EA per 1 day)
CHLORINE ANTISEPTICS**		
H-CHLOR 12 EXTERNAL SOLUTION 0.125 % (*sodium hypochlorite*)	Preferred	
HYSEPT 25 EXTERNAL SOLUTION 0.25 % (*sodium hypochlorite*)	Preferred	
CITRATES**		
potassium citrate er oral tablet extended release 10 meq (1080 mg), 15 meq (1620 mg), 5 meq (540 mg)	Preferred	
potassium citrate-citric acid oral solution 1100-334 mg/5ml	Preferred	
sod citrate-citric acid oral solution 1.5-1 gm/15ml, 3-2 gm/30ml, 500-334 mg/5ml	Preferred	
COBALAMINS**		
cyanocobalamin injection solution 1000 mcg/ml	Preferred	
sm vitamin b-12 oral tablet 100 mcg, 500 mcg	Preferred	
true vitamin b12 oral tablet 1000 mcg, 500 mcg	Preferred	
vitamin b-12 oral tablet 1000 mcg, 250 mcg	Preferred	
cyanocobalamin (Dodex Injection Solution 1000 Mcg/Ml)	Preferred	
COMBINATION CONTRACEPTIVES - ORAL**		
alyacen 1/35 oral tablet 1-35 mg-mcg	Preferred	Max 365-day supply per 1 Fill
briellyn oral tablet 0.4-35 mg-mcg	Preferred	Max 365-day supply per 1 Fill
drospiren-eth estrad-levomefol oral tablet 3-0.02-0.451 mg, 3-0.03-0.451 mg	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg, 3-0.03 mg	Preferred	Max 365-day supply per 1 Fill
ethynodiol diac-eth estradiol oral tablet 1-35 mg-mcg, 1-50 mg-mcg	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-30 mg-mcg	Preferred	Max 365-day supply per 1 Fill
marlissa oral tablet 0.15-30 mg-mcg	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe oral capsule 1-20 mg-mcg(24)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe oral tablet chewable 1-20 mg-mcg(24)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg	Preferred	Max 365-day supply per 1 Fill
norethin-eth estradiol-fe oral tablet chewable 0.4-35 mg-mcg, 0.8-25 mg-mcg	Preferred	Max 365-day supply per 1 Fill
norgestimate-eth estradiol oral tablet 0.25-35 mg-mcg	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Afirmelle Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Altavera Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Apri Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Aubra Eq Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Aurovela 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Aurovela 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Aurovela Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Aurovela Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Aviane Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Ayuna Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Balziva Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Blisovi Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Blisovi Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
norethin ace-eth estrad-fe (Charlotte 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Chateal Eq Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestrel-ethinyl estradiol (Cryselle-28 Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Cyred Eq Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Dasetta 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Delyla Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestrel-ethinyl estradiol (Elinest Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Enskyce Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestimate-eth estradiol (Estarylla Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Falmina Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Finzala Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Gemmily Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Hailey 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Hailey Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Hailey Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Isibloom Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Jasmiel Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Juleber Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Junel 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Junel 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Junel Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Junel Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estradiol-fe (Kaitlib Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
desogestrel-ethinyl estradiol (Kalliga Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
ethynodiol diac-eth estradiol (Kelnor 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
ethynodiol diac-eth estradiol (Kelnor 1/50 Oral Tablet 1-50 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Kurvelo Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Larin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Larin 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Larin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Larin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estradiol-fe (Layolis Fe Oral Tablet Chewable 0.8-25 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Lessina Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Levora 0.15/30 (28) Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Loestrin 1.5/30 (21) Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Loestrin 1/20 (21) Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Loestrin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Loestrin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Loryna Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
norgestrel-ethinyl estradiol (Low-Ogestrel Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Lo-Zumandimine Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Lutera Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Merzee Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Mibelas 24 Fe Oral Tablet Chewable 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Microgestin 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone acet-ethinyl est (Microgestin 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
norethin ace-eth estrad-fe (Microgestin Fe 1.5/30 Oral Tablet 1.5-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Microgestin Fe 1/20 Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestimate-eth estradiol (Mili Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestimate-eth estradiol (Mono-Linyah Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Necon 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Nikki Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Nortrel 0.5/35 (28) Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Nortrel 1/35 (21) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Nortrel 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Nylia 1/35 Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Ocella Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Philith Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Portia-28 Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
desogestrel-ethinyl estradiol (Reclipsen Oral Tablet 0.15-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestimate-eth estradiol (Sprintec 28 Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorgestrel-ethinyl estrad (Sronyx Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Syeda Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Tarina Fe 1/20 Eq Oral Tablet 1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin ace-eth estrad-fe (Taysofy Oral Capsule 1-20 Mg-Mcg(24))	Preferred	Max 365-day supply per 1 Fill
norgestrel-ethinyl estradiol (Turqoz Oral Tablet 0.3-30 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
TYBLUME ORAL TABLET CHEWABLE 0.1-20 MG-MCG (*levonorgestrel-ethinyl estrad*)	Preferred	Max 365-day supply per 1 Fill
drospiren-eth estrad-levomefol (Tydemy Oral Tablet 3-0.03-0.451 Mg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Vestura Oral Tablet 3-0.02 Mg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
levonorgestrel-ethinyl estrad (Vienva Oral Tablet 0.1-20 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Vyfemla Oral Tablet 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestimate-eth estradiol (Vylibra Oral Tablet 0.25-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindrone-eth estradiol (Wera Oral Tablet 0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estradiol-fe (Wymzya Fe Oral Tablet Chewable 0.4-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
ethynodiol diac-eth estradiol (Zovia 1/35 (28) Oral Tablet 1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
drospirenone-ethinyl estradiol (Zumandimine Oral Tablet 3-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
COMBINATION CONTRACEPTIVES - TRANSDERMAL**		
norelgestromin-eth estradiol transdermal patch weekly 150-35 mcg/24hr	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per 1 Fill
norelgestromin-eth estradiol (Xulane Transdermal Patch Weekly 150-35 Mcg/24Hr)	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per 1 Fill
norelgestromin-eth estradiol (Zafemy Transdermal Patch Weekly 150-35 Mcg/24Hr)	Preferred	QL (0.12 EA per 1 day); Max 365-day supply per 1 Fill
COMBINATION CONTRACEPTIVES - VAGINAL**		
etonogestrel-ethinyl estradiol vaginal ring 0.12-0.015 mg/24hr	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
etonogestrel-ethinyl estradiol (Eluryng Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
etonogestrel-ethinyl estradiol (Enilloring Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
etonogestrel-ethinyl estradiol (Haloette Vaginal Ring 0.12-0.015 Mg/24Hr)	Preferred	QL (0.04 EA per 1 day); Max 365-day supply per 1 Fill
CONDOMS - MALE**		
aimsco lubricated	Preferred	
kimono	Preferred	
kimono micro thin	Preferred	
kimono micro thin plus	Preferred	
kimono plus	Preferred	
kimono ps	Preferred	
kimono ps plus	Preferred	
kimono sensation	Preferred	
kimono sensation plus	Preferred	
maxx	Preferred	
maxx plus	Preferred	
true cover device	Preferred	
DUREX EXTRA SENSITIVE THIN (*condoms latex lubricated*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
DUREX EXTRA SENSITIVE THIN DEVICE (*condoms latex lubricated*)	Preferred	
DUREX REALFEEL DEVICE (*condoms non-latex lubricated*)	Preferred	
DUREX TROPICAL (*condoms latex lubricated*)	Preferred	
FANTASY LUBRICATED (*condoms latex lubricated*)	Preferred	
FANTASY LUBRICATED/SPERMICIDE (*condoms latex lubricated*)	Preferred	
KAMELEON LUBRICATED (*condoms latex lubricated*)	Preferred	
KIMONO COLORS DEVICE (*condoms latex lubricated*)	Preferred	
KIMONO MAXX-LARGE FLARE (*condoms latex lubricated*)	Preferred	
KIMONO SPECIAL DEVICE (*condoms latex lubricated*)	Preferred	
REALITY LATEX CONDOMS (*condoms latex lubricated*)	Preferred	
REALITY LATEX/ULTRA TEXTURED DEVICE (*condoms latex lubricated*)	Preferred	
REALITY LATEX/ULTRA THIN DEVICE (*condoms latex lubricated*)	Preferred	
TRUSTEX COLOR CONDOMS + LUBE (*condoms latex lubricated*)	Preferred	
TRUSTEX LUB/RIBBED/STUDDED (*condoms latex lubricated*)	Preferred	
TRUSTEX LUB/SPERMICIDE EX ST (*condoms latex lubricated*)	Preferred	
TRUSTEX LUB/SPERMICIDE XL (*condoms latex lubricated*)	Preferred	
TRUSTEX LUBRICATED (*condoms latex lubricated*)	Preferred	
TRUSTEX LUBRICATED EX LARGE (*condoms latex lubricated*)	Preferred	
TRUSTEX LUBRICATED EXTRA ST (*condoms latex lubricated*)	Preferred	
TRUSTEX LUBRICATED/SPERMICIDE (*condoms latex lubricated*)	Preferred	
TRUSTEX NATURAL CONDOMS + LUBE (*condoms latex lubricated*)	Preferred	
TRUSTEX NON-LUBRICATED (*condoms latex non-lubricated*)	Preferred	
TRUSTEX RIA LUB/SPERMICIDE (*condoms latex lubricated*)	Preferred	
TRUSTEX RIA LUBRICATED (*condoms latex lubricated*)	Preferred	
TRUSTEX RIA NON-LUBRICATED (*condoms latex non-lubricated*)	Preferred	
TRUSTEX-NONOXYNOL-9/RIB/STUD (*condoms latex lubricated*)	Preferred	
CORTICOSTEROIDS - TOPICAL**		
hydrocortisone external ointment 0.5 %	Preferred	
sm hydrocortisone external ointment 0.5 %	Preferred	
AQUANIL HC EXTERNAL LOTION 1 % (*hydrocortisone*)	Preferred	
CYCLOPLEGIC MYDRIATICS**		
atropine sulfate ophthalmic solution 1 %	Preferred	
cyclopentolate hcl ophthalmic solution 1 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
tropicamide ophthalmic solution 1 %	Preferred	
CYCLOSPORINE ANALOGS**		
cyclosporine modified oral capsule 100 mg, 25 mg	Preferred	
cyclosporine modified oral solution 100 mg/ml	Preferred	
cyclosporine modified (Gengraf Oral Capsule 100 Mg, 25 Mg)	Preferred	
cyclosporine modified (Gengraf Oral Solution 100 Mg/Ml)	Preferred	
DECONGESTANT & ANTIHISTAMINE**		
nohist-lq oral liquid 4-10 mg/5ml	Preferred	
promethazine vc oral syrup 6.25-5 mg/5ml	Preferred	AGE (Min 6 Years)
promethazine-phenylephrine oral syrup 6.25-5 mg/5ml	Preferred	AGE (Min 6 Years)
rynex pe oral elixir 1-2.5 mg/5ml	Preferred	
rynex pse oral liquid 1-15 mg/5ml	Preferred	
sm cold & allergy childrens oral elixir 1-15 mg/5ml	Preferred	
sm cold & allergy pe oral tablet 4-10 mg	Preferred	
sm sinus & allergy max st oral tablet 4-60 mg	Preferred	
APRODINE ORAL TABLET 2.5-60 MG (*triprolidine-pseudoephedrine*)	Preferred	
CONEX COLD/ALLERGY ORAL SOLUTION 1-30 MG/5ML (*dexbrompheniramine-pseudoeph*)	Preferred	
CONEX COLD/ALLERGY ORAL TABLET 2-60 MG (*dexbrompheniramine-pseudoeph*)	Preferred	
CONEX COLD/ALLERGY PEDIATRIC ORAL SOLUTION 1-30 MG/5ML (*dexbrompheniramine-pseudoeph*)	Preferred	
ED A-HIST ORAL LIQUID 4-10 MG/5ML (*chlorpheniramine-phenylephrine*)	Preferred	
ED A-HIST ORAL TABLET 4-10 MG (*chlorpheniramine-phenylephrine*)	Preferred	
LOHIST-D ORAL LIQUID 2-30 MG/5ML (*chlorpheniramine-pseudoeph*)	Preferred	
SUDOGEST SINUS/ALLERGY ORAL TABLET 4-60 MG (*chlorpheniramine-pseudoeph*)	Preferred	
DECONGESTANT W/ EXPECTORANT**		
ft mucus relief d 12 hour oral tablet extended release 12 hour 60-600 mg	Preferred	
mucus d oral tablet extended release 12 hour 120-1200 mg	Preferred	
mucus relief d oral tablet extended release 12 hour 120-1200 mg, 60-600 mg	Preferred	
pseudoephedrine-guaifenesin er oral tablet extended release 12 hour 120-1200 mg, 60-600 mg	Preferred	
DECONGESTANT-ANALGESIC**		
cold & sinus oral tablet 30-200 mg	Preferred	
gnp sinus pressure/pain oral tablet 5-325 mg	Preferred	
gnp sinus/headache oral tablet 5-325 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
hm cold & sinus relief oral tablet 30-200 mg	Preferred	
sinus + headache oral tablet 5-325 mg	Preferred	
sinus congestion/pain oral tablet 5-325 mg	Preferred	
sinus pressure + pain oral tablet 5-325 mg	Preferred	
sm cold & sinus relief oral tablet 30-200 mg	Preferred	
DECONGESTANT-ANALGESIC-EXPECTORANT**		
ft sinus severe oral tablet 5-325-200 mg	Preferred	
gnp cold/head congestion oral tablet 5-325-200 mg	Preferred	
gnp mucus relf sinus con/pain oral tablet 5-325-200 mg	Preferred	
gnp sinus severe daytime oral tablet 5-325-200 mg	Preferred	
head congestion/mucus oral tablet 5-325-200 mg	Preferred	
sinus relief congestion-pain oral tablet 5-325-200 mg	Preferred	
sm sinus severe for adults oral tablet 5-325-200 mg	Preferred	
DECONGESTANT-ANTIHISTAMINE-ANALGESIC**		
allergy multi-symptom oral tablet 2-5-325 mg	Preferred	
ft allergy multi-symptom oral tablet 2-5-325 mg	Preferred	
gnp allergy multi-symptom oral tablet 2-5-325 mg	Preferred	
sm flu relief therapy night oral liquid 12.5-5-325 mg/15ml	Preferred	
DIABETIC OTHER - COMBINATIONS**		
sm glucose oral tablet chewable 4-6 gm-mg	Preferred	
DIABETIC OTHER**		
sm glucose oral tablet chewable 4 gm	Preferred	
GLUTOSE 15 ORAL GEL 40 % (*dextrose (diabetic use)*)	Preferred	
GLUTOSE 45 ORAL GEL 40 % (*dextrose (diabetic use)*)	Preferred	
GLUTOSE 5 ORAL GEL 40 % (*dextrose (diabetic use)*)	Preferred	
INSTA-GLUCOSE ORAL GEL 77.4 % (*dextrose (diabetic use)*)	Preferred	
DIAGNOSTIC TESTS**		
RELION TRUE METRIX TEST STRIPS IN VITRO STRIP (*glucose blood*)	Preferred	PA (Eligible for auto-PA approval); QL (8 strips/day for up to 18 years old, insulin users, or pregnancy; 4 strips/day for all others); QL (10 EA per 1 day)
TRUE METRIX BLOOD GLUCOSE TEST IN VITRO STRIP (*glucose blood*)	Preferred	PA (Eligible for auto-PA approval); QL (8 strips/day for up to 18 years old, insulin users, or pregnancy; 4 strips/day for all others); QL (10 EA per 1 day)
DIARRHEA COMBINATIONS - OPIATES**		
ft anti-diarrheal/anti-gas oral tablet 2-125 mg	Preferred	
gnp anti-diarrheal/anti-gas oral tablet 2-125 mg	Preferred	
goodsense anti-diarr/ant-gas oral tablet 2-125 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
loperamide-simethicone oral tablet 2-125 mg	Preferred	
DIETARY MANAGEMENT PRODUCT COMBINATIONS**		
l-methylfolate forte oral capsule 15-90.314 mg, 7.5-90.314 mg	Preferred	
l-methyl-mc oral tablet 6-1-50-5 mg	Preferred	
westab max oral tablet 2.5-25-2 mg	Preferred	
FOLBIC ORAL TABLET 2.5-25-2 MG (*fa-pyridoxine-cyanocobalamin*)	Preferred	
FOLBIC RF ORAL TABLET 1.13-25-2 MG (*l-methylfolate-b6-b12*)	Preferred	
FOLTANX ORAL TABLET 3-35-2 MG (*l-methylfolate-b6-b12*)	Preferred	
METAFOLBIC ORAL TABLET 6-1-50-5 MG (*l-methylfolate-b12-b6-b2*)	Preferred	
NIVA-FOL ORAL TABLET 2.5-25-2 MG (*fa-pyridoxine-cyanocobalamin*)	Preferred	
DISPOSABLE GLOVES**		
cotton gloves medium	Preferred	
cvs gloves	Preferred	
cvs gloves vinyl	Preferred	
cvs latex gloves small	Preferred	
cvs nitrile exam gloves	Preferred	
cvs nyplex gloves	Preferred	
cvs super-soft vinyl gloves	Preferred	
eql latex exam gloves	Preferred	
eql nitrile exam gloves	Preferred	
eql vinyl exam gloves	Preferred	
eql vinyl gloves one size	Preferred	
gnp latex exam gloves	Preferred	
gnp nitrile exam gloves	Preferred	
gnp vinyl exam gloves	Preferred	
latex gloves	Preferred	
latex gloves large	Preferred	
latex gloves medium	Preferred	
latex gloves one size	Preferred	
latex gloves small	Preferred	
lavender nitrile gloves/medium	Preferred	
nitrile exam gloves large	Preferred	
nitrile exam gloves medium	Preferred	
nitrile gloves large	Preferred	
nitrile gloves medium	Preferred	
nitrile gloves small	Preferred	
nitrile gloves x-large	Preferred	

Drug Name	Formulary Status	Requirements/Limits
nitrile gloves/one size	Preferred	
nitrile gloves/size 10	Preferred	
nitrile gloves/size 6	Preferred	
nitrile gloves/size 6.5	Preferred	
nitrile gloves/size 7	Preferred	
nitrile gloves/size 7.5	Preferred	
nitrile gloves/size 8	Preferred	
nitrile gloves/size 8.5	Preferred	
nitrile gloves/size 9	Preferred	
nitrile gloves/size 9.5 medium	Preferred	
powder free nitrile gloves lg	Preferred	
powder free nitrile gloves med	Preferred	
powder free nitrile gloves sm	Preferred	
powder free nitrile gloves xl	Preferred	
pro comfort gloves large	Preferred	
pro comfort gloves medium	Preferred	
pro comfort gloves x-large	Preferred	
pro-comfort examination gloves	Preferred	
ra extended cuff nitrile glove	Preferred	
ra heavy duty latex gloves	Preferred	
ra vinyl gloves	Preferred	
synthetic vinyl exam gloves	Preferred	
ultra-soft gloves	Preferred	
vinyl gloves	Preferred	
vinyl gloves medium	Preferred	
vinyl gloves one size	Preferred	
ALLERGARD SURGICAL GLOVES (*disposable gloves*)	Preferred	
ASSURANCE VINYL EXAM GLOVES (*disposable gloves*)	Preferred	
CAREMATES LATEX-PF GLOVE LARGE (*disposable gloves*)	Preferred	
CAREMATES LATEX-PF GLOVE MED (*disposable gloves*)	Preferred	
CAREMATES LATEX-PF GLOVE SMALL (*disposable gloves*)	Preferred	
CAREMATES LATEX-PF GLOVE XL (*disposable gloves*)	Preferred	
CAREMATES NITRILE GLOVES LARGE (*disposable gloves*)	Preferred	
CAREMATES NITRILE GLOVES MED (*disposable gloves*)	Preferred	
CAREMATES NITRILE GLOVES SMALL (*disposable gloves*)	Preferred	
CAREMATES NITRILE GLOVES XL (*disposable gloves*)	Preferred	
CHEMOPLUS LATEX GLOVES (*disposable gloves*)	Preferred	
CHEMOPLUS NEOPRENE GLOVE (*disposable gloves*)	Preferred	
CHEMOPLUS NITRILE GLOVES (*disposable gloves*)	Preferred	
CLEVER CHOICE COMFORT EZ GLOVE (*disposable gloves*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
COMFORT TOUCH VINYL GLOVES/L (*disposable gloves*)	Preferred	
COMFORT TOUCH VINYL GLOVES/M (*disposable gloves*)	Preferred	
COMFORT TOUCH VINYL GLOVES/S (*disposable gloves*)	Preferred	
DIGITEX EXAM GLOVES (*disposable gloves*)	Preferred	
J & J HEALTH CARE GLOVES (*disposable gloves*)	Preferred	
MAXXUS ORTHO SURGICAL GLOVES (*disposable gloves*)	Preferred	
MICRO-TOUCH GLOVES (*disposable gloves*)	Preferred	
MICRO-TOUCH XP GLOVES (*disposable gloves*)	Preferred	
NEUTRALON 50 BROWN LATEX GLOVE (*disposable gloves*)	Preferred	
NEUTRALON BROWN SURGICAL GLOVE (*disposable gloves*)	Preferred	
PURE-COMFORT DISPOSABLE VINYL (*disposable gloves*)	Preferred	
PURE-COMFORT NITRILE EXAM (*disposable gloves*)	Preferred	
PURE-COMFORT SYNTHETIC NITRILE (*disposable gloves*)	Preferred	
RELION NITRILE EXAM GLOVES (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-L (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-M (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-S (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLK-NITRL-XL (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-L (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-M (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-S (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVE-BLUE-NITRL-XL (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVES-NITRILE-L (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVES-NITRILE-M (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVES-NITRILE-S (*disposable gloves*)	Preferred	
SAFE-SENSE GLOVES-NITRILE-XL (*disposable gloves*)	Preferred	
SAFESKIN NITRILE EXAM GLOVES (*disposable gloves*)	Preferred	
SECURE GLOVES (*disposable gloves*)	Preferred	
SHAMROCK LATEX EXAM GLOVES (*disposable gloves*)	Preferred	
SHAMROCK VINYL EXAM GLOVES (*disposable gloves*)	Preferred	
SURGIKOS LATEX SURGICAL GLOVES (*disposable gloves*)	Preferred	
TRANQUILITY VINYL GLOVES LARGE (*disposable gloves*)	Preferred	
TRANQUILITY VINYL GLOVES MED (*disposable gloves*)	Preferred	
TRANQUILITY VINYL GLOVES SMALL (*disposable gloves*)	Preferred	
DIURETIC COMBINATIONS**		
amiloride-hydrochlorothiazide oral tablet 5-50 mg	Preferred	
spironolactone-hctz oral tablet 25-25 mg	Preferred	
triamterene-hctz oral capsule 37.5-25 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
triamterene-hctz oral tablet 37.5-25 mg, 75-50 mg	Preferred	90-day fill allowed after two 1-month fills
DOPAMINE RECEPTOR AGONISTS**		
cabergoline oral tablet 0.5 mg	Preferred	
DRY MOUTH AGENTS AND ARTIFICIAL SALIVA**		
AQUORAL MOUTH/THROAT SOLUTION (*artificial saliva*)	Preferred	
ELECTROLYTES ORAL**		
gnp electrolyte solution oral solution	Preferred	
gnp pediatric electrolyte oral solution	Preferred	
hydrating electrolyte oral packet	Preferred	
sm pediatric electrolyte oral solution	Preferred	
ORALYTE ORAL SOLUTION (*oral electrolytes*)	Preferred	
REHYDRALYTE ORAL SOLUTION (*oral electrolytes*)	Preferred	
EMERGENCY CONTRACEPTIVES**		
levonorgestrel oral tablet 1.5 mg	Preferred	
AFTERA ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
AFTERPILL ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
CURAE ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
ECONTRA ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
HER STYLE ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
MY CHOICE ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
MY WAY ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
NEW DAY ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
OPCICON ONE-STEP ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
OPTION 2 ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
REACT ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
TAKE ACTION ORAL TABLET 1.5 MG (*levonorgestrel*)	Preferred	
EMOLLIENT COMBINATIONS**		
mineral oil-hydrophil petrolat external ointment	Preferred	
EMOLLIENT/KERATOLYTIC AGENTS**		
urea 20 intensive hydrating external cream 20 %	Preferred	
urea external cream 20 %	Preferred	
ureacin-10 external lotion 10 %	Preferred	
ureacin-20 external cream 20 %	Preferred	
NUTRAPLUS EXTERNAL CREAM 10 % (*urea*)	Preferred	
NUTRAPLUS EXTERNAL LOTION 10 % (*urea*)	Preferred	
EMOLLIENTS**		
a&d external ointment	Preferred	
ammonium lactate external cream 12 %	Preferred	
ammonium lactate external lotion 12 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
sm dry skin therapy external lotion	Preferred	
thera-derm external lotion	Preferred	
vitamin a & d external ointment	Preferred	
AMLACTIN DAILY EXTERNAL LOTION 12 % (*ammonium lactate*)	Preferred	
AQUA GLYCOLIC HAND/BODY EXTERNAL LOTION (*emollient*)	Preferred	
AQUA LACTEN EXTERNAL LOTION (*emollient*)	Preferred	
AQUAMED EXTERNAL LOTION (*emollient*)	Preferred	
CAM EXTERNAL LOTION (*emollient*)	Preferred	
CORN HUSKERS EXTERNAL LOTION (*emollient*)	Preferred	
DML EXTERNAL LOTION (*emollient*)	Preferred	
LUBRISOFT EXTERNAL LOTION (*emollient*)	Preferred	
MINERIN EXTERNAL LOTION (*emollient*)	Preferred	
NUTRADERM ADVANCED FORMULA EXTERNAL LOTION (*emollient*)	Preferred	
NUTRADERM EXTERNAL LOTION (*emollient*)	Preferred	
WIBI EXTERNAL LOTION (*emollient*)	Preferred	
ESTROGEN & PROGESTIN**		
estradiol-norethindrone acet oral tablet 1-0.5 mg	Preferred	QL (1 EA per 1 day)
estradiol-norethindrone acet (Mimvey Oral Tablet 1-0.5 Mg)	Preferred	QL (1 EA per 1 day)
ESTROGENS**		
estradiol oral tablet 0.5 mg, 1 mg, 2 mg	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
estradiol transdermal patch twice weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	Preferred	QL (0.29 EA per 1 day)
estradiol transdermal patch weekly 0.025 mg/24hr, 0.0375 mg/24hr, 0.05 mg/24hr, 0.075 mg/24hr, 0.1 mg/24hr	Preferred	QL (0.15 EA per 1 day)
estradiol valerate intramuscular oil 40 mg/ml	Preferred	
ALORA TRANSDERMAL PATCH TWICE WEEKLY 0.025 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR (*estradiol*)	Preferred	QL (0.29 EA per 1 day)
estradiol (Dotti Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	Preferred	QL (0.29 EA per 1 day)
estradiol (Lyllana Transdermal Patch Twice Weekly 0.025 Mg/24Hr, 0.0375 Mg/24Hr, 0.05 Mg/24Hr, 0.075 Mg/24Hr, 0.1 Mg/24Hr)	Preferred	QL (0.29 EA per 1 day)
EXPECTORANTS**		
chest congestion relief oral liquid 100 mg/5ml	Preferred	
chest congestion relief oral tablet 400 mg	Preferred	
ft chest congestion relief oral tablet 400 mg	Preferred	
ft mucus relief 12hr oral tablet extended release 12 hour 1200 mg, 600 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
ft tussin adult oral liquid 200 mg/10ml	Preferred	
gnp mucus er oral tablet extended release 12 hour 1200 mg, 600 mg	Preferred	
gnp mucus relief oral tablet 400 mg	Preferred	
gnp tab tussin oral tablet 400 mg	Preferred	
gnp tussin mucus & chest cong oral liquid 100 mg/5ml	Preferred	
goodsense mucus er maximum str oral tablet extended release 12 hour 1200 mg	Preferred	
goodsense mucus er oral tablet extended release 12 hour 600 mg	Preferred	
guaifenesin er oral tablet extended release 12 hour 1200 mg, 600 mg	Preferred	
guaifenesin oral liquid 100 mg/5ml	Preferred	
guaifenesin oral tablet 200 mg	Preferred	
mucus & chest congestion oral liquid 200 mg/10ml	Preferred	
mucus relief er oral tablet extended release 12 hour 600 mg	Preferred	
mucus relief max st oral tablet extended release 12 hour 1200 mg	Preferred	
mucus relief oral tablet extended release 12 hour 600 mg	Preferred	
siltussin sa oral liquid 100 mg/5ml	Preferred	
sm chest congestion relief oral tablet 400 mg	Preferred	
sm mucus relief childrens oral liquid 100 mg/5ml	Preferred	
sm mucus relief max strength oral tablet extended release 12 hour 1200 mg	Preferred	
sm mucus relief oral tablet extended release 12 hour 600 mg	Preferred	
sm tussin mucus+chest congest oral liquid 100 mg/5ml	Preferred	
tussin mucus & chest congest oral liquid 100 mg/5ml	Preferred	
tussin mucus+chest congestion oral liquid 100 mg/5ml	Preferred	
TUSNEL-EX ORAL LIQUID 100 MG/5ML (*guaifenesin*)	Preferred	
EXTENDED-CYCLE CONTRACEPTIVES - ORAL**		
levonorgest-eth estrad 91-day oral tablet 0.1-0.02 & 0.01 mg, 0.15-0.03 &0.01 mg, 0.15-0.03 mg	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Ashlyna Oral Tablet 0.15-0.03 &0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Camrese Lo Oral Tablet 0.1-0.02 & 0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Camrese Oral Tablet 0.15-0.03 &0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Daysee Oral Tablet 0.15-0.03 &0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Iclevia Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
levonorgest-eth estrad 91-day (Introvale Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Jaimiess Oral Tablet 0.15-0.03 &0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Jolessa Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Lojaimiess Oral Tablet 0.1-0.02 & 0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Setlakin Oral Tablet 0.15-0.03 Mg)	Preferred	Max 365-day supply per 1 Fill
levonorgest-eth estrad 91-day (Simpesse Oral Tablet 0.15-0.03 &0.01 Mg)	Preferred	Max 365-day supply per 1 Fill
EXTERNAL VEHICLE INGREDIENTS**		
methylcellulose powder	Preferred	
FIXED OILS**		
castor oil oil	Preferred	
qc castor oil oil	Preferred	
sesame oil oil	Preferred	
FLAVORING AGENTS**		
almond oil bitter flavor liquid	Preferred	
anise extract liquid	Preferred	
apple flavor liquid	Preferred	
apricot flavor liquid	Preferred	
bacon flavor liquid	Preferred	
banana concentrate liquid	Preferred	
banana cream flavor liquid	Preferred	
banana creme flavor liquid	Preferred	
banana flavor liquid	Preferred	
beef (grilled) flavor oil sol liquid	Preferred	
beef braised natural flavor liquid	Preferred	
beef flavor liquid	Preferred	
beef type flavor natural liquid	Preferred	
beef type flavor os liquid	Preferred	
bitter stop flavor liquid	Preferred	
bitterness mask flavor liquid	Preferred	
bitterness suppressor flavor liquid	Preferred	
blackberry flavor liquid	Preferred	
blood orange os liquid	Preferred	
blueberry flavor liquid	Preferred	
bubble gum concentrate liquid	Preferred	
bubble gum flavor liquid	Preferred	
bubble gum os liquid	Preferred	

Drug Name	Formulary Status	Requirements/Limits
bubble gum ws liquid	Preferred	
butter flavor liquid	Preferred	
butter rum flavor liquid	Preferred	
butterscotch flavor liquid	Preferred	
caramel flavor liquid	Preferred	
caramel os liquid	Preferred	
cheesecake flavor liquid	Preferred	
cherry flavor liquid	Preferred	
chicken (grilled) flavor liquid	Preferred	
chicken conc flavor liquid	Preferred	
chicken flavor liquid	Preferred	
chicken flavor oil miscible liquid	Preferred	
chicken flavor oil soluble liquid	Preferred	
chicken flavor water miscible liquid	Preferred	
chicken roasted concentrate liquid	Preferred	
chocolate flavor liquid	Preferred	
chocolate hazelnut flavor liquid	Preferred	
coconut flavor liquid	Preferred	
coffee flavor liquid	Preferred	
cola flavor liquid	Preferred	
cotton candy flavor liquid	Preferred	
cran-raspberry flavor liquid	Preferred	
creme de menthe flavor liquid	Preferred	
creme dementhe flavor liquid	Preferred	
creme os liquid	Preferred	
english toffee flavor liquid	Preferred	
eugenol flavor liquid	Preferred	
fish flavor liquid	Preferred	
grape concord os liquid	Preferred	
grape flavor liquid	Preferred	
green apple os liquid	Preferred	
guava flavor liquid	Preferred	
ham flavor liquid	Preferred	
honey flavor liquid	Preferred	
kahlua flavor liquid	Preferred	
lemon extract liquid	Preferred	
lemon flavor liquid	Preferred	
licorice flavor liquid	Preferred	
liver concentrate liquid	Preferred	
liver flavor liquid	Preferred	

Drug Name	Formulary Status	Requirements/Limits
mango flavor liquid	Preferred	
mango passion fruit os liquid	Preferred	
maple flavor liquid	Preferred	
marshmallow flavor liquid	Preferred	
marshmallow os liquid	Preferred	
mint chocolate chip flavor liquid	Preferred	
natural caramel liquid	Preferred	
orange concentrate liquid	Preferred	
orange cream flavor liquid	Preferred	
orange flavor liquid	Preferred	
orange oil flavor liquid	Preferred	
peach flavor liquid	Preferred	
peanut butter flavor liquid	Preferred	
peppermint burst os liquid	Preferred	
pina colada flavor liquid	Preferred	
pineapple flavor liquid	Preferred	
pralines and cream flavor liquid	Preferred	
pumpkin flavor liquid	Preferred	
raspberry flavor liquid	Preferred	
raspberry os liquid	Preferred	
root beer flavor liquid	Preferred	
sardine flavor liquid	Preferred	
shrimp flavor liquid	Preferred	
spearmint os liquid	Preferred	
stevia glycerite extract liquid	Preferred	
strawberry flavor liquid	Preferred	
strawberry os liquid	Preferred	
sweetening enhancer liquid	Preferred	
tropical fusion os liquid	Preferred	
tropical punch flavor liquid	Preferred	
tuna flavor liquid	Preferred	
tuna type flavor os liquid	Preferred	
tutti frutti flavor liquid	Preferred	
tutti-frutti flavor liquid	Preferred	
vanilla butternut flavor liquid	Preferred	
vanilla flavor liquid	Preferred	
vanilla os liquid	Preferred	
very berry os liquid	Preferred	
vitamin/iron masking agent liquid	Preferred	
watermelon flavor liquid	Preferred	

Drug Name	Formulary Status	Requirements/Limits
wild cherry flavor liquid	Preferred	
wild cherry os liquid	Preferred	
FLAVORX LIQUID (*flavoring agent*)	Preferred	
MARSHMALLOW WS LIQUID (*flavoring agent*)	Preferred	
PCCA SWEETNESS ENHANCER LIQUID (*flavoring agent*)	Preferred	
SWEET DROPS LIQUID (*flavoring agent*)	Preferred	
TROPICAL FUSION WS LIQUID (*flavoring agent*)	Preferred	
FLUORIDE DENTAL PRODUCTS**		
fraiche 5000 dental dental gel 1.1 %	Preferred	
sodium fluoride 5000 plus dental cream 1.1 %	Preferred	
sodium fluoride 5000 ppm dental cream 1.1 %	Preferred	
sodium fluoride 5000 ppm dental gel 1.1 %	Preferred	
sodium fluoride dental gel 1.1 %	Preferred	
sodium fluoride (Denta 5000 Plus Dental Cream 1.1 %)	Preferred	
sodium fluoride (Dentagel Dental Gel 1.1 %)	Preferred	
FLUORIDE**		
sodium fluoride oral solution 1.1 (0.5 f) mg/ml	Preferred	
sodium fluoride oral tablet chewable 0.55 (0.25 f) mg, 1.1 (0.5 f) mg, 2.2 (1 f) mg	Preferred	
SOLUVITA ORAL SOLUTION 0.5 MG/ML (*sodium fluoride*)	Preferred	
FOLIC ACID ANTAGONISTS RESCUE AGENTS**		
leucovorin calcium oral tablet 10 mg, 15 mg, 25 mg, 5 mg	Preferred	
FOLIC ACID/FOLATES**		
folic acid oral tablet 1 mg	Preferred	
sm folic acid oral tablet 400 mcg	Preferred	
true folic acid oral tablet 1 mg, 400 mcg	Preferred	
FOUR PHASE CONTRACEPTIVES - ORAL**		
NATAZIA ORAL TABLET 3/2-2/2-3/1 MG (*estradiol valerate-dienogest*)	Preferred	Max 365-day supply per 1 Fill
GENITOURINARY IRRIGANTS**		
acetic acid irrigation solution 0.25 %	Preferred	
sodium chloride irrigation solution 0.9 %	Preferred	
GLUCOSE MONITORING TEST SUPPLIES**		
acti-lance 28g	Preferred	Max 100-day supply per 1 Fill
acti-lance lite lancets 28g	Preferred	Max 100-day supply per 1 Fill
acti-lance special lancets 17g	Preferred	Max 100-day supply per 1 Fill
acti-lance universal 23g	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
adjustable lancing device	Preferred	Max 100-day supply per 1 Fill
advanced mobile lancet	Preferred	Max 100-day supply per 1 Fill
aimsco twist lancets 32g	Preferred	Max 100-day supply per 1 Fill
assure comfort lancets 28g	Preferred	Max 100-day supply per 1 Fill
aurora lancet super thin 30g	Preferred	Max 100-day supply per 1 Fill
aurora lancet thin 23g	Preferred	Max 100-day supply per 1 Fill
careone advanced lancing dev	Preferred	Max 100-day supply per 1 Fill
careone lancet thin 23g	Preferred	Max 100-day supply per 1 Fill
comfort assured lancets 28g	Preferred	Max 100-day supply per 1 Fill
comfort assured lancets 33g	Preferred	Max 100-day supply per 1 Fill
cvs lancets 21g	Preferred	Max 100-day supply per 1 Fill
cvs lancets micro thin 33g	Preferred	Max 100-day supply per 1 Fill
cvs lancets original	Preferred	Max 100-day supply per 1 Fill
cvs lancets thin 26g	Preferred	Max 100-day supply per 1 Fill
cvs lancets ultra thin 30g	Preferred	Max 100-day supply per 1 Fill
cvs lancets ultra-thin 30g	Preferred	Max 100-day supply per 1 Fill
cvs lancing device	Preferred	Max 100-day supply per 1 Fill
cvs ultra thin lancets	Preferred	Max 100-day supply per 1 Fill
drug mart lancets thin 26g	Preferred	Max 100-day supply per 1 Fill
easy comfort lancets	Preferred	Max 100-day supply per 1 Fill
easy comfort lancets twist top	Preferred	Max 100-day supply per 1 Fill
easy mini eject lancing device	Preferred	Max 100-day supply per 1 Fill
easy mini lancing device	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
embrace lancing device/ejector	Preferred	Max 100-day supply per 1 Fill
eql color lancets 21g	Preferred	Max 100-day supply per 1 Fill
eql color lancets micro 33g	Preferred	Max 100-day supply per 1 Fill
eql super thin lancets 30g	Preferred	Max 100-day supply per 1 Fill
eql thin lancets 26g	Preferred	Max 100-day supply per 1 Fill
global inject ease lancets 28g	Preferred	Max 100-day supply per 1 Fill
global inject ease lancets 30g	Preferred	Max 100-day supply per 1 Fill
global lancing device	Preferred	Max 100-day supply per 1 Fill
gnp lancets 21g	Preferred	Max 100-day supply per 1 Fill
gnp lancets thin 26g	Preferred	Max 100-day supply per 1 Fill
gnp sterile lancets 28g	Preferred	Max 100-day supply per 1 Fill
gnp sterile lancets 30g	Preferred	Max 100-day supply per 1 Fill
gnp sterile lancets 33g	Preferred	Max 100-day supply per 1 Fill
goodsense color lancets 33g	Preferred	Max 100-day supply per 1 Fill
goodsense lancets 26g univ	Preferred	Max 100-day supply per 1 Fill
goodsense lancets 30g	Preferred	Max 100-day supply per 1 Fill
goodsense lancets 30g univ	Preferred	Max 100-day supply per 1 Fill
goodsense lancets 33g	Preferred	Max 100-day supply per 1 Fill
goodsense lancets 33g univ	Preferred	Max 100-day supply per 1 Fill
goodsense lancing device	Preferred	Max 100-day supply per 1 Fill
h-e-b incontrol adv lancing	Preferred	Max 100-day supply per 1 Fill
h-e-b incontrol lancets 28g	Preferred	Max 100-day supply per 1 Fill
h-e-b incontrol lancets 30g	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
h-e-b incontrol lancets 33g	Preferred	Max 100-day supply per 1 Fill
hy-vee thin lancets	Preferred	Max 100-day supply per 1 Fill
kinney lancets	Preferred	Max 100-day supply per 1 Fill
kinney thin lancets	Preferred	Max 100-day supply per 1 Fill
kroger lancets	Preferred	Max 100-day supply per 1 Fill
kroger lancets 21g	Preferred	Max 100-day supply per 1 Fill
kroger lancets micro thin 33g	Preferred	Max 100-day supply per 1 Fill
kroger lancets super thin	Preferred	Max 100-day supply per 1 Fill
kroger lancets thin	Preferred	Max 100-day supply per 1 Fill
kroger lancets thin 26g	Preferred	Max 100-day supply per 1 Fill
kroger lancets ultrathin 30g	Preferred	Max 100-day supply per 1 Fill
kroger lancing device	Preferred	Max 100-day supply per 1 Fill
lancet device	Preferred	Max 100-day supply per 1 Fill
lancet device with ejector	Preferred	Max 100-day supply per 1 Fill
lancets	Preferred	Max 100-day supply per 1 Fill
lancets 30g	Preferred	Max 100-day supply per 1 Fill
lancets 33g	Preferred	Max 100-day supply per 1 Fill
lancets micro thin 33g	Preferred	Max 100-day supply per 1 Fill
lancets super thin 28g	Preferred	Max 100-day supply per 1 Fill
lancets thin	Preferred	Max 100-day supply per 1 Fill
lancets ultra thin 30g	Preferred	Max 100-day supply per 1 Fill
lancing device	Preferred	Max 100-day supply per 1 Fill
leader advanced lancing device	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
lite touch lancets	Preferred	Max 100-day supply per 1 Fill
live better lancet super thin	Preferred	Max 100-day supply per 1 Fill
longs lancets standard	Preferred	Max 100-day supply per 1 Fill
longs lancets thin	Preferred	Max 100-day supply per 1 Fill
longs lancets ultra thin	Preferred	Max 100-day supply per 1 Fill
medichoice safety lancet	Preferred	Max 100-day supply per 1 Fill
medichoice safety lancet extra	Preferred	Max 100-day supply per 1 Fill
medichoice safety lancet norm	Preferred	Max 100-day supply per 1 Fill
mini lancing device	Preferred	Max 100-day supply per 1 Fill
multi-lancet device	Preferred	Max 100-day supply per 1 Fill
pip lancets 28g	Preferred	Max 100-day supply per 1 Fill
pip lancets 30g	Preferred	Max 100-day supply per 1 Fill
preferred plus lancets colored	Preferred	Max 100-day supply per 1 Fill
preferred plus lancets thin	Preferred	Max 100-day supply per 1 Fill
pro comfort lancets 30g	Preferred	Max 100-day supply per 1 Fill
pro comfort lancets 31g	Preferred	Max 100-day supply per 1 Fill
pro comfort safety lancets 30g	Preferred	Max 100-day supply per 1 Fill
pure comfort lancets 30g	Preferred	Max 100-day supply per 1 Fill
px advanced lancing device	Preferred	Max 100-day supply per 1 Fill
px lancets microthin 33g	Preferred	Max 100-day supply per 1 Fill
px lancets ultra thin 28g	Preferred	Max 100-day supply per 1 Fill
qc advanced lancing device	Preferred	Max 100-day supply per 1 Fill
qc lancets super thin 30g	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
qc lancets ultra thin	Preferred	Max 100-day supply per 1 Fill
qc unilet lancets 28g	Preferred	Max 100-day supply per 1 Fill
qc unilet lancets micro thin	Preferred	Max 100-day supply per 1 Fill
reality lancets	Preferred	Max 100-day supply per 1 Fill
reality trigger lancets	Preferred	Max 100-day supply per 1 Fill
safety lancet 30g/pressure act	Preferred	Max 100-day supply per 1 Fill
safety lancets 28g	Preferred	Max 100-day supply per 1 Fill
saps health plus lancets	Preferred	Max 100-day supply per 1 Fill
saps health twist top lancets	Preferred	Max 100-day supply per 1 Fill
saps twist top lancets	Preferred	Max 100-day supply per 1 Fill
sapscare twist top lancets	Preferred	Max 100-day supply per 1 Fill
sb lancets thin	Preferred	Max 100-day supply per 1 Fill
sb lancets ultra thin	Preferred	Max 100-day supply per 1 Fill
select-lite device/lancets kit	Preferred	Max 100-day supply per 1 Fill
select-lite lancing device	Preferred	Max 100-day supply per 1 Fill
sm lancets 33g	Preferred	Max 100-day supply per 1 Fill
super thin lancets	Preferred	Max 100-day supply per 1 Fill
sure comfort lancets 18g	Preferred	Max 100-day supply per 1 Fill
sure comfort lancets 21g	Preferred	Max 100-day supply per 1 Fill
sure comfort lancets 23g	Preferred	Max 100-day supply per 1 Fill
sure comfort lancets 28g	Preferred	Max 100-day supply per 1 Fill
sure comfort lancets 30g	Preferred	Max 100-day supply per 1 Fill
sure comfort lancing pen	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
tgt lancet micro thin 33g	Preferred	Max 100-day supply per 1 Fill
tgt lancet thin 26g	Preferred	Max 100-day supply per 1 Fill
tgt lancet ultra thin 30g	Preferred	Max 100-day supply per 1 Fill
tgt lancing device	Preferred	Max 100-day supply per 1 Fill
todays health lancing device	Preferred	Max 100-day supply per 1 Fill
todays health thin lancets 28g	Preferred	Max 100-day supply per 1 Fill
todays health thin lancets 30g	Preferred	Max 100-day supply per 1 Fill
topcare lancets micro-thin 33g	Preferred	Max 100-day supply per 1 Fill
true comfort safety lancets	Preferred	Max 100-day supply per 1 Fill
true comfort twist top lancets	Preferred	Max 100-day supply per 1 Fill
twist top lancets 30g	Preferred	Max 100-day supply per 1 Fill
ultra thin lancets 31g	Preferred	Max 100-day supply per 1 Fill
ultra-care lancets 30g	Preferred	Max 100-day supply per 1 Fill
value plus lancet standard 21g	Preferred	Max 100-day supply per 1 Fill
value plus lancets super thin	Preferred	Max 100-day supply per 1 Fill
value plus lancets thin 26g	Preferred	Max 100-day supply per 1 Fill
value plus lancing device	Preferred	Max 100-day supply per 1 Fill
walgreens lancets micro thin	Preferred	Max 100-day supply per 1 Fill
walgreens lancets super thin	Preferred	Max 100-day supply per 1 Fill
zevrx twist top lancets 30g	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK FASTCLIX LANCET KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK FASTCLIX LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK SAFE-T PRO LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
ACCU-CHEK SOFTCLIX LANCET DEV KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
ACCU-CHEK SOFTCLIX LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE RAPID-SAFE LANCING (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ADVOCATE SAFETY LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
AGAMATRIX ULTRA-THIN LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
AIMSCO TWIST LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
AQUALANCE LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE PLUS SAFETY 25G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE PLUS SAFETY 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ASSURE LANCE SAFETY LANCET 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
AUTO-LANCET (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
AUTO-LANCET MINI (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
AUTOLET II CLINISAFE KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
AUTOLET LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
AUTOLET LITE CLINISAFE KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
AUTOLET LITE STARTER PACK KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
AUTOLET MINI (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
AUTOLET PLATFORMS (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
AUTOLET PLUS (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
BD MICROTAINER LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARDIOCOM LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
CAREONE LANCET SUPER THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARESENS LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARESENS LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH LANCING/EJECTOR (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH SAFETY LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CARETOUCH TWIST MC LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CHOSEN LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CHOSEN LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
CHOSEN SAFETY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CLEANLET LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHEK LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE COMFORT EZ (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE LANCETS 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
CLEVER CHOICE LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
COAGUCHEK LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH LANCETS 31G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH PLUS LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH PLUS LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
COMFORT TOUCH TWIST LANCET 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DEXCOM G5 MOB/G4 PLAT SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (4 EA per 28 days)
DEXCOM G5 MOBILE RECEIVER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G5 MOBILE TRANSMITTER (*continuous glucose transmitter*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 90 days); 90-day fill allowed after two 1-month fills
DEXCOM G5 RECEIVER KIT DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G6 RECEIVER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G6 SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 30 days)
DEXCOM G6 TRANSMITTER (*continuous glucose transmitter*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 90 days); 90-day fill allowed after two 1-month fills
DEXCOM G7 RECEIVER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
DEXCOM G7 SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (3 EA per 30 days)
DIATHRIVE LANCET ULTRA THIN 30 (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DIATHRIVE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DIATHRIVE LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
DROPLET GENTEEL LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
DROPLET LANCETS ULTRA THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DROPLET LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
DROPLET PERSONAL LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DRUG MART ON-THE-GO LANCET 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DRUG MART UNILET LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DRUG MART UNILET LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
DRUG MART UNILET LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 28G/TWIST (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 30G/TWIST (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 32G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 32G/TWIST (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCETS 33G/TWIST (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EASY TOUCH SAFETY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
EMBRACE LANCETS ULTRA THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EMBRACE PRESSURE ACTIVATED 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EMBRACE PRESSURE ACTIVATED 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCET MICRO-THIN 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCET SUPER THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
E-Z JECT LANCETS THIN 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
EZ-LETS LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
FIFTY50 SAFETY SEAL LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
FIFTY50 UNILET LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
FINGERSTIX LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
FORA LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
FORA LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
FREESTYLE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
FREESTYLE LIBRE 14 DAY READER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
FREESTYLE LIBRE 14 DAY SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE 2 READER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
FREESTYLE LIBRE 2 SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE 3 PLUS SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE 3 READER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
FREESTYLE LIBRE 3 SENSOR (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE LIBRE READER DEVICE (*continuous glucose receiver*)	Preferred	PA (Eligible for auto-PA approval); QL (1 EA per 365 days); Max 365-day supply per 1 Fill
FREESTYLE LIBRE SENSOR SYSTEM (*continuous glucose sensor*)	Preferred	PA (Eligible for auto-PA approval); QL (2 EA per 28 days)
FREESTYLE UNISTICK II LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL BUTTERFLY TOUCH LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (BLUE) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (CLEAR) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (GREEN) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (ORANGE) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (RAINBOW) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (VIOLET) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL CONTACT TIPS (YELLOW) (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL LANCING KIT (BLUE) KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL NOZZLES (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING (BLACK) (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING (PURPLE) (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
GENTEEL PLUS LANCING (WHITE) (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING DEV(BLUE) (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
GENTEEL PLUS LANCING DEV(PINK) (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
GLUCOCOM LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
GLUCOCOM LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
GLUCOCOM LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
GNP LANCING SYSTEM DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
GOJJI LANCING DEVICE/CLEAR CAP (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
GOJJI STERILE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE LOW FLOW LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS HIGH FLOW (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS LOW FLOW (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS MAX FLOW (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HAEMOLANCE PLUS PEDIATRIC FLOW (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HEALTH CARE LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
HYPOLANCE AST LANCING KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
HY-VEE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
IN TOUCH LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
IN TOUCH STERILE LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
KROGER AUTOLET LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
KROGER HEALTHPRO LANCET 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
LANCETS SUPER THIN (*lancets*)	Preferred	Max 100-day supply per 1 Fill
LANCETS ULTRA THIN (*lancets*)	Preferred	Max 100-day supply per 1 Fill
LANZO (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
LIBERTY MEDICAL LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
LIBERTY MINI LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
LITE TOUCH LANCING PEN (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
LITETOUCH LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS EXTRA 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS LITE 25G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS SPECIAL 0.8MM (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS SUPERLITE 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEDLANCE PLUS UNIVERSAL 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS THIN (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS UNIVERSAL 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS UNIVERSAL 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEIJER LANCETS UNIVERSAL 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MEIJER SUPER THIN LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MICROLET LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MICROLET NEXT LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
MM LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
MM TWIST LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MONOLET LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
MONOLET OPD LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MONOLETTOR SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
MULTI-LANCET DEVICE 2 KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
MYGLUCOHEALTH LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
NOVA SAFETY LANCETS 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
NOVA SAFETY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
NOVA SUREFLEX LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
NOVA SUREFLEX LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA PLUS LANCET30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA PLUS LANCET33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA PLUS LANCING (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH DELICA SAFETY LANCING (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ONETOUCH ULTRASOFT 2 LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PERFECT LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PERFECT LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PERFECT POINT SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PHARMACIST CHOICE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PHARMACY COUNTER LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PRODIGY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PRODIGY LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
PRODIGY SAFETY LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
PRODIGY TWIST TOP LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RA E-ZJECT LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
RA E-ZJECT LANCETS THIN 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RA E-ZJECT LANCETS THIN 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RA E-ZJECT LANCETS ULTRA THIN (*lancets*)	Preferred	Max 100-day supply per 1 Fill
READYLANCE SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCET DEVICES 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS MICRO-THIN 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS THIN 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCETS ULTRA-THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
RELION LANCING DEVICE KIT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
RELION ULTRA THIN LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RELION ULTRA THIN PLUS LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
REXALL LANCETS ULTRA THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
RIGHTEST ALTERNATE SITE ADAPT (*lancets misc.*)	Preferred	Max 100-day supply per 1 Fill
RIGHTEST GD500 LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
RIGHTEST GL300 LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SAFETY LANCETS 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SAFETY LANCETS 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SIMPLE DIAGNOSTICS LANCING DEV (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
SINGLE-LET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SM TRUEDRAW LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
SMART DIABETES VANTAGE LANCING (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE COLOR LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE STANDARD LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE SUPER THIN LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SMART SENSE THIN LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SMARTEST LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SOLUS V2 LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SOLUS V2 LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
SOLUS V2 TWIST LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
STERILANCE TL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
SURELITE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TECHLITE AST LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TECHLITE LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TECHLITE LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TRAVEL LANCETS ADVANCED 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TRUE METRIX LEVEL 1 IN VITRO SOLUTION LOW (*blood glucose calibration*)	Preferred	
TRUE METRIX LEVEL 2 IN VITRO SOLUTION NORMAL (*blood glucose calibration*)	Preferred	
TRUE METRIX LEVEL 3 IN VITRO SOLUTION HIGH (*blood glucose calibration*)	Preferred	
TRUEDRAW LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
TRUEPLUS LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
TRUEPLUS SAFETY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ULTI-LANCE AUTOMATIC (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
ULTILET CLASSIC LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ULTILET LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ULTILET SAFETY LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ULTILET SAFETY LANCETS 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ULTRA-THIN II AUTO LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
ULTRA-THIN II LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET COMFORTOUCH LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET EXCELITE (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET EXCELITE II (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET G.P. LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET G.P. SUPERLITE LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET GP 28 ULTRA THIN (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET MICRO-THIN 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET SUPERLITE LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET SUPER-THIN 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNILET ULTRA-THIN 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 1 (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 COMFORT (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 EXTRA (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
UNISTIK 2 NEONATAL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 NORMAL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 2 SUPER (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 COMFORT (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 EXTRA (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 GENTLE (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 NEONATAL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK 3 NORMAL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK CZT COMFORT (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK CZT NORMAL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK NORMAL (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK PRO SAFETY LANCET (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK SAFETY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK SAFETY LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNISTIK TOUCH SAFETY LANC 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNIVERSAL 1 LANCETS THIN 26G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNIVERSAL 1 LANCETS THIN 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
UNIVERSAL 1 LANCETS ULTRA THIN (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VERIFINE SAFE LANCET MINI 21G (*lancets*)	Preferred	Max 100-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
VERIFINE SAFE LANCET MINI 23G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VERIFINE SAFE LANCET MINI 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VERIFINE SAFE LANCET MINI 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VERIFINE UNIVERSAL LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VERIFINE UNIVERSAL LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VERIFINE UNIVERSAL LANCETS 33G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD LANCETS 30G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD LANCING DEVICE (*lancet devices*)	Preferred	Max 100-day supply per 1 Fill
VIVAGUARD SAFETY LANCETS 28G (*lancets*)	Preferred	Max 100-day supply per 1 Fill
WALGREENS LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
WALGREENS THIN LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
WALGREENS ULTRA THIN LANCETS (*lancets*)	Preferred	Max 100-day supply per 1 Fill
HEMATORHEOLOGIC AGENTS**		
pentoxifylline er oral tablet extended release 400 mg	Preferred	
HEMOSTATICS - SYSTEMIC**		
tranexamic acid oral tablet 650 mg	Preferred	QL (6 EA per 1 day)
HEPATITIS C AGENTS**		
ribavirin oral capsule 200 mg	Preferred	SP; QL (6 EA per 1 day)
ribavirin oral tablet 200 mg	Preferred	SP; QL (6 EA per 1 day)
HUMIDIFIERS**		
sm vaporizer cleaning tablet soluble	Preferred	
sm vaporizer inhalant liquid	Preferred	
GORDO-POOL CONCENTRATE (*humidifier/vaporizer supplies*)	Preferred	
KAZ BACTERIOSTATIC TREATMENT LIQUID (*humidifier/vaporizer supplies*)	Preferred	
KAZ INHALANT LIQUID (*humidifier/vaporizer supplies*)	Preferred	
KAZ WATER TREATMENT LIQUID (*humidifier/vaporizer supplies*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
HYDROLYTIC ENZYMES**		
PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML (*dornase alfa*)	Preferred	SP; PA; QL (5 ML per 1 day)
HYPERPARATHYROID TREATMENT - VITAMIN D ANALOGS**		
calcitriol oral capsule 0.25 mcg, 0.5 mcg	Preferred	
IMIDAZOLE-RELATED ANTIFUNGALS**		
3 day vaginal vaginal cream 2 %	Preferred	
clotrimazole vaginal cream 1 %	Preferred	
ft clotrimazole 3 vaginal cream 2 %	Preferred	
ft clotrimazole vaginal cream 1 %	Preferred	
ft miconazole 3 comb pack-supp vaginal kit 200 & 2 mg-% (9gm)	Preferred	
ft miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)	Preferred	
ft miconazole 7 vaginal cream 2 %	Preferred	
ft tioconazole-1 vaginal ointment 6.5 %	Preferred	
gnp clotrimazole 3 vaginal cream 2 %	Preferred	
gnp miconazole 1 vaginal kit 1200 & 2 mg & %	Preferred	
gnp miconazole 3 vaginal kit 200 & 2 mg-% (9gm)	Preferred	
gnp miconazole 7 vaginal cream 2 %	Preferred	
miconazole 3 combo pack vaginal kit 200 & 2 mg-% (9gm)	Preferred	
miconazole 3 combo-supp vaginal kit 200 & 2 mg-% (9gm)	Preferred	
miconazole 7 vaginal cream 2 %	Preferred	
miconazole 7 vaginal suppository 100 mg	Preferred	
miconazole nitrate vaginal cream 2 %	Preferred	
sm 3-day vaginal vaginal cream 2 %	Preferred	
sm clotrimazole vaginal vaginal cream 1 %	Preferred	
sm miconazole 3 applicator vaginal kit 200 & 2 mg-% (9gm)	Preferred	
sm miconazole 3 vaginal kit 200 & 2 mg-% (9gm)	Preferred	
sm miconazole 7 vaginal cream 2 %	Preferred	
sm miconazole 7 vaginal suppository 100 mg	Preferred	
sm tioconazole-1 vaginal ointment 6.5 %	Preferred	
terconazole vaginal cream 0.4 %, 0.8 %	Preferred	
terconazole vaginal suppository 80 mg	Preferred	QL (1.5 EA per 1 day)
tioconazole-1 vaginal ointment 6.5 %	Preferred	
IMIDAZOTETRAZINES**		
temozolomide oral capsule 100 mg, 140 mg, 180 mg, 20 mg, 250 mg, 5 mg	Preferred	SP; PA
IMMUNOMODULATORS IMIDAZOQUINOLINAMINES - TOPICAL**		
imiquimod external cream 5 %	Preferred	QL (0.434 EA per 1 day); AGE (Min 12 Years)

Drug Name	Formulary Status	Requirements/Limits
INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS**		
mycophenolate mofetil oral capsule 250 mg	Preferred	
mycophenolate mofetil oral tablet 500 mg	Preferred	
INSULIN ADMINISTRATION SUPPLIES**		
AMBI-TRAY (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/ADMELOG (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/APIDRA (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/ASPART (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/BASAGLAR (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/FIASP (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/HUMALOG (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/LANTUS (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/LISPRO (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/LYUMJEV (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/NOVOLOG (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/TOUJEO (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/TOUJEO M (*insulin admin supplies*)	Preferred	
BIGFOOT UNITY PEN CAP/TRESIBA (*insulin admin supplies*)	Preferred	
EASY TOUCH INSULIN BARRELS 1ML (*insulin admin supplies*)	Preferred	
INSUL-CAP (*insulin admin supplies*)	Preferred	
INSUL-EZE (*insulin admin supplies*)	Preferred	
OMNIPOD 5 DEXG7G6 INTRO GEN 5 KIT (*insulin disposable pump*)	Preferred	PA
OMNIPOD 5 DEXG7G6 PODS GEN 5 (*insulin disposable pump*)	Preferred	PA
OMNIPOD 5 LIBRE2 PLUS G6 KIT (*insulin disposable pump*)	Preferred	PA
OMNIPOD 5 LIBRE2 PLUS G6 PODS (*insulin disposable pump*)	Preferred	PA
OMNIPOD CLASSIC PODS (GEN 3) (*insulin disposable pump*)	Preferred	PA
OMNIPOD DASH INTRO (GEN 4) KIT (*insulin disposable pump*)	Preferred	PA
OMNIPOD DASH PDM (GEN 4) KIT (*insulin disposable pump*)	Preferred	PA
OMNIPOD DASH PODS (GEN 4) (*insulin disposable pump*)	Preferred	PA
OMNIPOD GO KIT 20 UNIT/24HR, 30 UNIT/24HR, 40 UNIT/24HR (*insulin disposable pump*)	Preferred	PA
OMNIPOD POD PALS (*insulin dispos pmp accessories*)	Preferred	PA
PRODIGY COUNT-A-DOSE (*insulin admin supplies*)	Preferred	
V-GO 20 KIT 20 UNIT/24HR (*insulin disposable pump*)	Preferred	PA
V-GO 30 KIT 30 UNIT/24HR (*insulin disposable pump*)	Preferred	PA
V-GO 40 KIT 40 UNIT/24HR (*insulin disposable pump*)	Preferred	PA
VIVI CAP (*insulin admin supplies*)	Preferred	
VIVI CAP1 (*insulin admin supplies*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
INTESTINAL ACIDIFIERS**		
enulose oral solution 10 gm/15ml	Preferred	
generlac oral solution 10 gm/15ml	Preferred	
lactulose encephalopathy oral solution 10 gm/15ml	Preferred	
IODINE ANTISEPTICS**		
first aid antiseptic external ointment 10 %	Preferred	
gnp povidone-iodine external solution 10 %	Preferred	
povidone-iodine external solution 10 %	Preferred	
sm povidone-iodine external solution 10 %	Preferred	
BETADINE EXTERNAL SOLUTION 10 % (*povidone-iodine*)	Preferred	
BETADINE SURGICAL SCRUB EXTERNAL SOLUTION 7.5 % (*povidone-iodine*)	Preferred	
IRON COMBINATIONS**		
ferocon oral capsule	Preferred	
foltrin oral capsule	Preferred	
trigels-f forte oral capsule 460-60-0.01-1 mg	Preferred	
FOLITAB 500 ORAL TABLET EXTENDED RELEASE 105-500-0.8 MG (*ferrous sulfate-c-folic acid*)	Preferred	
IRON**		
ferrous fumarate oral tablet 324 mg	Preferred	
ferrous gluconate oral tablet 324 (38 fe) mg	Preferred	
ferrous sulfate oral solution 220 (44 fe) mg/5ml, 300 (60 fe) mg/5ml, 300 mg/6.8ml, 75 (15 fe) mg/ml	Preferred	
ferrous sulfate oral tablet 325 (65 fe) mg	Preferred	90-day fill allowed after two 1-month fills
ferrous sulfate oral tablet delayed release 324 (65 fe) mg, 325 (65 fe) mg	Preferred	
gnp iron oral tablet 200 (65 fe) mg	Preferred	
gnp iron oral tablet extended release 45 mg	Preferred	
iron (ferrous sulfate) oral solution 75 (15 fe) mg/ml	Preferred	
iron chews pediatric oral tablet chewable 15 mg	Preferred	
iron infant/toddler oral solution 75 (15 fe) mg/ml	Preferred	
polysaccharide iron complex oral capsule 150 mg	Preferred	
sm iron oral tablet 325 (65 fe) mg	Preferred	90-day fill allowed after two 1-month fills
sm iron slow release oral tablet extended release 160 (50 fe) mg	Preferred	
sm slow release iron oral tablet extended release 143 (45 fe) mg	Preferred	
true ferrous sulfate oral tablet delayed release 324 mg	Preferred	
wee care oral suspension 15 mg/1.25ml	Preferred	
FERATE ORAL TABLET 240 (27 FE) MG (*ferrous gluconate*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
FEROSUL ORAL TABLET 325 (65 FE) MG (*ferrous sulfate*)	Preferred	90-day fill allowed after two 1-month fills
FERREX 150 ORAL CAPSULE 150 MG (*polysaccharide iron complex*)	Preferred	
FERRIMIN 150 ORAL TABLET 150 MG (*ferrous fumarate*)	Preferred	
FERROCITE ORAL TABLET 324 MG (*ferrous fumarate*)	Preferred	
NU-IRON ORAL CAPSULE 150 MG (*polysaccharide iron complex*)	Preferred	
IRRIGATION SOLUTIONS**		
sterile water for irrigation irrigation solution	Preferred	
water for irrigation, sterile irrigation solution	Preferred	
KERATOLYTIC/ANTIMITOTIC/VESICANT AGENTS**		
podofilox external solution 0.5 %	Preferred	
therapeutic dandruff external shampoo 3 %	Preferred	
DHS SAL EXTERNAL SHAMPOO 3 % (*salicylic acid*)	Preferred	
LAXATIVES - MISCELLANEOUS**		
constulose oral solution 10 gm/15ml	Preferred	
ft clearlax oral powder 17 gm/scoop	Preferred	
gavilax oral powder 17 gm/scoop	Preferred	
glycerin (adult) rectal suppository 2 gm	Preferred	
glycerin adult rectal suppository 2 gm	Preferred	
glycerin childrens rectal suppository 1 gm, 1.2 gm	Preferred	
gnp glycerin (adult) rectal suppository 2.1 gm	Preferred	
gnp glycerin child rectal suppository 1.2 gm	Preferred	
lactulose oral solution 10 gm/15ml, 20 gm/30ml	Preferred	
peg 3350 oral packet 17 gm	Preferred	
peg 3350 oral powder 17 gm/scoop	Preferred	
polyethylene glycol 3350 oral packet 17 gm	Preferred	
polyethylene glycol 3350 oral powder 17 gm/scoop	Preferred	
sm glycerin pediatric rectal suppository 1.2 gm, 80.7 %	Preferred	
true laxative oral powder 17 gm/scoop	Preferred	
CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	Preferred	
FLEET LIQUID GLYCERIN SUPP RECTAL ENEMA 5.4 GM/DOSE (*glycerin (laxative)*)	Preferred	
GLYCOLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	Preferred	
GNP CLEARLAX ORAL PACKET 17 GM (*polyethylene glycol 3350*)	Preferred	
GNP CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
GOODSENSE CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	Preferred	
HEALTHYLAX ORAL PACKET 17 GM (*polyethylene glycol 3350*)	Preferred	
HM CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	Preferred	
PEDIA-LAX RECTAL SUPPOSITORY 2.8 GM (*glycerin (laxative)*)	Preferred	
SM CLEARLAX ORAL POWDER 17 GM/SCOOP (*polyethylene glycol 3350*)	Preferred	
LAXATIVES & DSS**		
ft senna-s oral tablet 8.6-50 mg	Preferred	
ft stool softener oral tablet 50-8.6 mg	Preferred	
gnp senna plus oral tablet 8.6-50 mg	Preferred	
gnp stool softener/laxative oral tablet 8.6-50 mg	Preferred	
hm stool softener/laxative oral tablet 8.6-50 mg	Preferred	
senexon-s oral tablet 8.6-50 mg	Preferred	
senna plus oral tablet 8.6-50 mg	Preferred	
senna-docusate sodium oral tablet 8.6-50 mg	Preferred	
senna-time s oral tablet 8.6-50 mg	Preferred	
sennosides-docusate sodium oral tablet 8.6-50 mg	Preferred	
sm senna-s oral tablet 8.6-50 mg	Preferred	
sm stool softener/laxative oral tablet 8.6-50 mg	Preferred	
stimulant laxative oral tablet 8.6-50 mg	Preferred	
stool softener plus laxative oral tablet 8.6-50 mg	Preferred	
COLACE 2-IN-1 ORAL TABLET 8.6-50 MG (*sennosides-docusate sodium*)	Preferred	
SENOKOT S ORAL TABLET 8.6-50 MG (*sennosides-docusate sodium*)	Preferred	
LEPROSTATICS**		
dapsone oral tablet 100 mg, 25 mg	Preferred	
LEVODOPA COMBINATIONS**		
carbidopa-levodopa er oral tablet extended release 25-100 mg, 50-200 mg	Preferred	90-day fill allowed after two 1-month fills
carbidopa-levodopa oral tablet 10-100 mg, 25-100 mg, 25-250 mg	Preferred	90-day fill allowed after two 1-month fills
carbidopa-levodopa oral tablet dispersible 10-100 mg	Preferred	90-day fill allowed after two 1-month fills
carbidopa-levodopa-entacapone oral tablet 12.5-50-200 mg, 18.75-75-200 mg, 25-100-200 mg, 31.25-125-200 mg, 37.5-150-200 mg, 50-200-200 mg	Preferred	
DHIVY ORAL TABLET 25-100 MG (*carbidopa-levodopa*)	Preferred	90-day fill allowed after two 1-month fills
LINCOSAMIDES**		
clindamycin hcl oral capsule 150 mg, 300 mg	Preferred	QL (4 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
clindamycin palmitate hcl oral solution reconstituted 75 mg/5ml	Preferred	QL (70 ML per 1 day)
LOCAL ANESTHETICS - TOPICAL**		
ft pain relief max strength external patch 4 %	Preferred	
gnp lidocaine pain relief external patch 4 %	Preferred	
gnp lidocaine pain relieving external cream 4 %	Preferred	
lidocaine external cream 4 %	Preferred	
lidocaine external patch 4 %	Preferred	
lidocaine pain relief external patch 4 %	Preferred	
lidocaine pain relief max st external cream 4 %	Preferred	
lidocaine pain relief max st external patch 4 %	Preferred	
lidocaine pain relieving external patch 4 %	Preferred	
true lido external cream 4 %	Preferred	
ultra lido external cream 4 %	Preferred	
ultra lido external patch 4 %	Preferred	
LOOP DIURETICS**		
bumetanide oral tablet 0.5 mg, 1 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
bumetanide oral tablet 2 mg	Preferred	QL (5 EA per 1 day); 90-day fill allowed after two 1-month fills
furosemide oral solution 10 mg/ml, 8 mg/ml	Preferred	
furosemide oral tablet 20 mg, 40 mg, 80 mg	Preferred	90-day fill allowed after two 1-month fills
torsemide oral tablet 10 mg, 100 mg, 20 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
LUBRICANT LAXATIVES**		
enema mineral oil rectal enema	Preferred	
ft enema mineral oil rectal enema	Preferred	
ft mineral oil oral oil	Preferred	
gnp mineral oil oral oil	Preferred	
hm enema mineral oil rectal enema	Preferred	
mineral oil oral oil	Preferred	
sm mineral oil rectal enema	Preferred	
MACROLIDE IMMUNOSUPPRESSANTS**		
sirolimus oral solution 1 mg/ml	Preferred	AGE (Max 12 Years)
sirolimus oral tablet 0.5 mg, 2 mg	Preferred	
tacrolimus oral capsule 0.5 mg	Preferred	QL (2 EA per 1 day)
tacrolimus oral capsule 1 mg	Preferred	QL (8 EA per 1 day)
tacrolimus oral capsule 5 mg	Preferred	QL (4 EA per 1 day)

Drug Name	Formulary Status	Requirements/Limits
MAGNESIUM COMBINATIONS**		
BEELITH ORAL TABLET 362-20 MG (*magnesium oxide-pyridoxine hcl*)	Preferred	
SLOWMAG MG MUSCLE/HEART ORAL TABLET DELAYED RELEASE 71.5-119 MG (*magnesium cl-calcium carbonate*)	Preferred	
SLOW-MAG ORAL TABLET DELAYED RELEASE 71.5-119 MG (*magnesium cl-calcium carbonate*)	Preferred	
MAGNESIUM**		
magnesium lactate oral tablet extended release 84 mg (7meq)	Preferred	
magnesium oxide -mg supplement oral tablet 400 (240 mg) mg, 500 mg	Preferred	
sm magnesium oral tablet 250 mg	Preferred	
true magnesium oxide oral tablet 400 mg, 500 mg	Preferred	
MAGNESIUM-OXIDE ORAL TABLET 400 (240 MG) MG (*magnesium oxide*)	Preferred	
MAGONATE ORAL LIQUID 54 (MAG EQUIV) MG/5ML (*magnesium carbonate*)	Preferred	
MASKS**		
breathe comfort protect shield	Preferred	
cvs medical face masks earloop	Preferred	
cvs procedural mask	Preferred	
disposable face mask	Preferred	
disposable face mask 3-ply	Preferred	
ear-loop mask small	Preferred	
face mask	Preferred	
face mask earloop-style	Preferred	
face mask resp n-100 part	Preferred	
face mask respirator r-95 part	Preferred	
face masks 3 layer non-medical	Preferred	
kn95 disposable mask	Preferred	
kn95 medical protective mask	Preferred	
mask pediatric size 1"	Preferred	
n95 face mask	Preferred	
n95 parti respirator face mask	Preferred	
pediatric medium mask	Preferred	
pediatric small mask	Preferred	
surgical face mask/niosh n95	Preferred	
ACTEEV PROTECT FACE MASK (*masks*)	Preferred	
CLEVER CHOICE DISPOSABLE MASK (*masks*)	Preferred	
CLEVER CHOICE FACE MASK (*masks*)	Preferred	
EASY FLOW KN 95 (*masks*)	Preferred	
J & J GERM FILTER MASK (*masks*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
NEXCARE ALL PURPOSE MASK (*masks*)	Preferred	
NEXCARE EARLOOP MASK (*masks*)	Preferred	
SAFE-SENSE EARLOOP FACE MASK (*masks*)	Preferred	
SHIELD-SECURE FULL FACE SHIELD (*masks*)	Preferred	
MEDICAL WASTE DISPOSAL SYSTEMS**		
bd sharps container home	Preferred	QL (1 EA per 1 day)
cvs needle collection/disposal	Preferred	QL (1 EA per 1 day)
easy comfort sharps container	Preferred	QL (1 EA per 1 day)
sharps collector	Preferred	QL (1 EA per 1 day)
sharps container	Preferred	QL (1 EA per 1 day)
sharps disposal by mail system	Preferred	QL (1 EA per 1 day)
BD PHLEBOTOMY SHARPS COLLECTOR (*sharps container*)	Preferred	QL (1 EA per 1 day)
BD SHARPS COLLECTOR (*sharps container*)	Preferred	QL (1 EA per 1 day)
COMPLETE NEEDLE COLLECTION SYS (*sharps container*)	Preferred	QL (1 EA per 1 day)
MONOJECT SHARPS CONTAINER (*sharps container*)	Preferred	QL (1 EA per 1 day)
ULTILET SHARPS CONTAINER 1QT (*sharps container*)	Preferred	QL (1 EA per 1 day)
ULTILET SHARPS CONTAINER 2QT (*sharps container*)	Preferred	QL (1 EA per 1 day)
VERIFINE SHARPS CONTAINER (*sharps container*)	Preferred	QL (1 EA per 1 day)
MINERALOCORTICOIDS**		
fludrocortisone acetate oral tablet 0.1 mg	Preferred	
MISC. ANTI-ULCER**		
sucralfate oral suspension 1 gm/10ml	Preferred	
sucralfate oral tablet 1 gm	Preferred	
MISC. NUTRITIONAL SUBSTANCES**		
fish oil high potency oral capsule 1000 mg	Preferred	
fish oil oral capsule 1000 mg, 500 mg	Preferred	
sm fish oil oral capsule 1000 mg	Preferred	
sm omega-3 fish oil oral capsule 1200 mg	Preferred	
SEA-OMEGA ORAL CAPSULE 1000 MG (*omega-3 fatty acids*)	Preferred	
MISC. RESPIRATORY INHALANTS**		
sodium chloride inhalation nebulization solution 0.9 %	Preferred	
MISC. TOPICAL COMBINATIONS**		
calamine external lotion 8-8 %	Preferred	
gnp calamine external lotion 8-8 %	Preferred	
sm calamine external lotion	Preferred	
MISC. TOPICAL**		
hemorrhoidal external pad 50 %	Preferred	
hm medicated cooling external pad 50 %	Preferred	
medi-pads external pad 50 %	Preferred	
sm medicated wipes external pad 50 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
MITOTIC INHIBITORS**		
etoposide oral capsule 50 mg	Preferred	
MIXED ADRENERGICS**		
ASTHMANEFRIN REFILL INHALATION NEBULIZATION SOLUTION 2.25 % (*racepinephrine hcl*)	Preferred	
S2 (RACEPINEPHRINE) INHALATION NEBULIZATION SOLUTION 2.25 % (*racepinephrine hcl*)	Preferred	
MUCOLYTICS**		
acetylcysteine inhalation solution 10 %, 20 %	Preferred	
MULTIPLE VITAMINS W/ IRON**		
sm multiple vitamins/iron oral tablet	Preferred	
MULTIPLE VITAMINS W/ MINERALS**		
dialyvite 800/ultra d oral tablet	Preferred	
glucoten oral capsule	Preferred	
gnp healthy eyes oral tablet	Preferred	
gnp mega multi for men oral tablet	Preferred	
gnp mega multi for women oral tablet	Preferred	
gnp one daily mens health 50+ oral tablet	Preferred	
gnp one daily mens/lycopene oral tablet	Preferred	
gnp one daily womens 50+ oral tablet	Preferred	
gnp one daily womens oral tablet	Preferred	
i-vite oral tablet	Preferred	
multiple vitamins-minerals oral liquid	Preferred	
multivit/multimineral adult oral liquid	Preferred	
sm complete advanced formula oral tablet	Preferred	
sm complete oral tablet	Preferred	
sm complete senior formula oral tablet	Preferred	
sm daily diet support oral tablet	Preferred	
sm opti-vitamins oral tablet	Preferred	
v-c forte oral capsule	Preferred	
CEROVITE SENIOR ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
CERTAVITE/ANTIOXIDANTS ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
COMPETE ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ICAPS LUTEIN & OMEGA-3 ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
ICAPS MV ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
ICAPS ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
multiple vitamins-minerals (Nutrifac Zx Oral Tablet)	Preferred	
OCUVITE EXTRA ORAL TABLET (*multiple vitamins-minerals*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
OCUVITE EYE + MULTI ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
OCUVITE EYE HEALTH FORMULA ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
OCUVITE EYE HEATLH GUMMIES ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
OCUVITE-LUTEIN ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
PRESERVISION AREDS 2 ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
PROSIGHT ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
RENAPLEX ORAL TABLET (*multiple vitamins-minerals*)	Preferred	
SYSTANE ICAPS AREDS2 ORAL CAPSULE (*multiple vitamins-minerals*)	Preferred	
SYSTANE ICAPS AREDS2 ORAL TABLET CHEWABLE (*multiple vitamins-minerals*)	Preferred	
multiple vitamins-minerals (Vita S Forte Oral Tablet)	Preferred	
MULTIVITAMINS**		
daily-vite oral tablet	Preferred	
gnp essential one daily oral tablet	Preferred	
sm multiple vitamins essential oral tablet	Preferred	
stress formula oral tablet	Preferred	
true daily vite oral tablet	Preferred	
TAB-A-VITE/BETA CAROTENE ORAL TABLET (*multiple vitamin*)	Preferred	
NASAL AGENTS - MISC.**		
deep sea nasal spray nasal solution 0.65 %	Preferred	
saline mist spray nasal solution 0.65 %	Preferred	
saline nasal spray nasal solution 0.65 %	Preferred	
sm nasal spray saline nasal solution 0.65 %	Preferred	
true nasal moisturizing nasal solution 0.65 %	Preferred	
AFRIN SALINE NASAL MIST NASAL SOLUTION 0.65 % (*saline*)	Preferred	
OCEAN FOR KIDS NASAL SOLUTION 0.65 % (*saline*)	Preferred	
NASAL MAST CELL STABILIZERS**		
cromolyn sodium nasal aerosol solution 5.2 mg/act	Preferred	
NATURAL PENICILLINS**		
penicillin v potassium oral solution reconstituted 125 mg/5ml, 250 mg/5ml	Preferred	
penicillin v potassium oral tablet 250 mg, 500 mg	Preferred	
NEEDLES & SYRINGES**		
1st tier unifine pentips 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
1st tier unifine pentips plus 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
aum mini insulin pen needle 32g x 5 mm , 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
aum pen needle 32g x 5 mm , 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
careone unifine pentips plus 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
carepoint poly hub needle 18g x 1" , 18g x 1-1/2" , 20g x 1" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"	Preferred	
carepoint poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"	Preferred	90-day fill allowed after two 1-month fills
carepoint safety 1st needle 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"	Preferred	
carepoint safety 1st needle 25g x 5/8"	Preferred	90-day fill allowed after two 1-month fills
carepoint syringe luer lock 1 ml	Preferred	
carepoint syringe luer slip 1 ml	Preferred	
carepoint tubercln syr/luer sl 25g x 5/8" 1 ml	Preferred	
easy comfort pen needles 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
easy glide pen needles 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
easy glide slip lock syringe 1 ml	Preferred	
hypodermic needle 18g x 1" , 18g x 1-1/2" , 20g x 1" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1-1/2" , 27g x 1-1/2"	Preferred	
hypodermic needle 25g x 5/8" , 27g x 1/2"	Preferred	90-day fill allowed after two 1-month fills
insulin syringe-needle u-100 31g x 1/4" 0.3 ml	Preferred	90-day fill allowed after two 1-month fills
kmart valu insulin syringe 29g u-100 1 ml	Preferred	90-day fill allowed after two 1-month fills
kmart valu insulin syringe 30g u-100 1 ml	Preferred	90-day fill allowed after two 1-month fills
kroger pen needles 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
pen needles 30g x 5 mm , 30g x 8 mm , 32g x 5 mm , 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
poly hub needle 18g x 1" , 18g x 1-1/2" , 22g x 1" , 22g x 1-1/2" , 23g x 1" , 23g x 1-1/2" , 25g x 1" , 25g x 1-1/2"	Preferred	
poly hub needle 25g x 5/8" , 27g x 1/2" , 30g x 1/2"	Preferred	90-day fill allowed after two 1-month fills
pro comfort pen needles 32g x 5 mm	Preferred	90-day fill allowed after two 1-month fills
pure comfort pen needle 32g x 5 mm	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
safety pen needles 30g x 5 mm , 30g x 8 mm	Preferred	90-day fill allowed after two 1-month fills
sure comfort insulin syringe 31g x 1/4" 0.3 ml	Preferred	90-day fill allowed after two 1-month fills
sure comfort pen needles 30g x 8 mm	Preferred	90-day fill allowed after two 1-month fills
syringe luer lock 20g x 1" 10 ml, 20g x 1" 3 ml, 21g x 1" 3 ml, 21g x 1-1/2" 3 ml, 22g x 1" 3 ml, 22g x 1-1/2" 3 ml, 23g x 1" 3 ml, 23g x 1-1/2" 3 ml, 25g x 1" 3 ml, 25g x 1-1/2" 3 ml, 25g x 5/8" 3 ml	Preferred	
syringe luer slip 1 ml	Preferred	
techlite insulin syringe 29g x 1/2" 0.3 ml, 29g x 1/2" 0.5 ml, 29g x 1/2" 1 ml, 30g x 1/2" 0.3 ml, 30g x 1/2" 0.5 ml, 30g x 1/2" 1 ml, 30g x 5/16" 0.3 ml, 30g x 5/16" 0.5 ml, 30g x 5/16" 1 ml, 31g x 15/64" 0.3 ml, 31g x 15/64" 0.5 ml, 31g x 15/64" 1 ml, 31g x 5/16" 0.3 ml, 31g x 5/16" 0.5 ml, 31g x 5/16" 1 ml	Preferred	90-day fill allowed after two 1-month fills
true comfort pro pen needles 32g x 5 mm , 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
ultracare pen needles 32g x 5 mm , 33g x 4 mm	Preferred	90-day fill allowed after two 1-month fills
ADVOCATE INSULIN PEN NEEDLES 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
ASSURE ID PRO PEN NEEDLES 30G X 5 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
ASSURE ID SAFETY PEN NEEDLES 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
BD ALLERGY SYRINGE 28G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
BD AUTOSHIELD DUO 30G X 5 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
BD BLUNT FILL NEEDLE 18G X 1-1/2" (*needle (disp)*)	Preferred	
BD BLUNT FILTER NEEDLE 18G X 1-1/2" (*needle (disp)*)	Preferred	
BD DISP NEEDLE 23G X 1" , 25G X 1" (*needle (disp)*)	Preferred	
BD DISP NEEDLES 18G X 1-1/2" , 20G X 1" , 22G X 1-1/2" (*needle (disp)*)	Preferred	
BD DISP NEEDLES 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
BD ECLIPSE LUER-LOK NEEDLE 30G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
BD ECLIPSE NEEDLE 18G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" (*needle (disp)*)	Preferred	
BD ECLIPSE NEEDLE 25G X 5/8" , 27G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
BD ECLIPSE SHIELDED NEEDLE 18G X 1-1/2" (*needle (disp)*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
BD ECLIPSE SYRINGE 21G X 1" 3 ML, 25G X 1" 3 ML (*syringe/needle (disp)*)	Preferred	
BD ECLIPSE SYRINGE/NEEDLE 22G X 1" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
BD FILTER NEEDLE/5 MICRON (*needles & syringes*)	Preferred	
BD HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1-1/2" (*needle (disp)*)	Preferred	
BD INSULIN SYRINGE MICROFINE 27G X 5/8" 1 ML (*insulin syringe-needle u-100*)	Preferred	90-day fill allowed after two 1-month fills
BD INSULIN SYRINGE U-100 1 ML (*insulin syringes (disposable)*)	Preferred	90-day fill allowed after two 1-month fills
BD INSULIN SYRINGE U-500 31G X 6MM 0.5 ML (*insulin syringe/needle u-500*)	Preferred	90-day fill allowed after two 1-month fills
BD INTEGRA NEEDLE 23G X 1" (*needle (disp)*)	Preferred	
BD INTEGRA SYRINGE 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
BD LUER-LOCK SYRINGE 18G X 1-1/2" 3 ML (*syringe/needle (disp)*)	Preferred	
BD LUER-LOK SYRINGE 18G X 1-1/2" 3 ML, 20G X 1" 1 ML, 20G X 1" 10 ML, 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1" 5 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
BD NOKOR ADMIX NEEDLE 18G X 1-1/2" (*needle (disp)*)	Preferred	
BD PLASTIPAK SYRINGE 21G X 1" 3 ML (*syringe/needle (disp)*)	Preferred	
BD PRECISIONGLIDE NEEDLE 23G X 1-1/2" , 27G X 1-1/2" (*needle (disp)*)	Preferred	
BD SAFETYGLIDE ALLERGY SYRINGE 27G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
BD SAFETYGLIDE NEEDLE 18G X 1-1/2" , 25G X 1" (*needle (disp)*)	Preferred	
BD SAFETYGLIDE NEEDLE 21G X 1-1/2" 3 ML (*syringe/needle (disp)*)	Preferred	
BD SAFETYGLIDE NEEDLE 25G X 5/8" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
BD SAFETYGLIDE SHIELDED NEEDLE 22G X 1-1/2" , 23G X 1" (*needle (disp)*)	Preferred	
BD SAFETYGLIDE SYRINGE/NEEDLE 25G X 1" 3 ML (*syringe/needle (disp)*)	Preferred	
BD SYRINGE LUER-LOK 1 ML (*syringe (disposable)*)	Preferred	
BD SYRINGE SLIP TIP 1 ML (*syringe (disposable)*)	Preferred	
BD SYRINGE SLIP TIP 25G X 5/8" 1 ML (*tuberculin-allergy syringes*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
BD SYRINGE/NEEDLE 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
BD TB SYRINGE 27G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
CAREFINE PEN NEEDLES 30G X 8 MM , 32G X 5 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
CAREPOINT SAFETY1ST SYR/NEEDLE 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
CAREPOINT SYRINGE LUER LOCK 20G X 1" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML (*syringe/needle (disp)*)	Preferred	
CARETOUCH HYPODERMIC NEEDLE 18G X 1-1/2" , 20G X 1" , 22G X 1" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (*needle (disp)*)	Preferred	
CARETOUCH HYPODERMIC NEEDLE 25G X 5/8" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
CARETOUCH LUER LOCK 1 ML (*syringe (disposable)*)	Preferred	
CARETOUCH LUER LOCK 23G X 1" 3 ML (*syringe/needle (disp)*)	Preferred	
CARETOUCH LUER LOCK SYR/NEEDLE 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
CARETOUCH LUER SLIP 1 ML (*syringe (disposable)*)	Preferred	
CARETOUCH PEN NEEDLES 32G X 5 MM , 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
CLEVER CHOICE COMFORT EZ 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
COMFORT EZ PEN NEEDLES 32G X 5 MM , 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
COMFORT EZ PRO PEN NEEDLES 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
COMFORT TOUCH INSULIN PEN NEED 32G X 5 MM , 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
DROPLET PEN NEEDLES 30G X 8 MM , 32G X 5 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
DROPSAFE SICURA 25G X 1" (*needle (disp)*)	Preferred	
EASY GLIDE LUER LOCK SYRINGE 1 ML (*syringe (disposable)*)	Preferred	
EASY TOUCH ALLERGY SYRINGE 27G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" (*needle (disp)*)	Preferred	
EASY TOUCH FLIPLOCK NEEDLES 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
EASY TOUCH FLIPLOCK SAFETY SYR 18G X 1-1/2" 3 ML, 20G X 1" 10 ML, 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
EASY TOUCH HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 23G X 1-1/2" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (*needle (disp)*)	Preferred	
EASY TOUCH HYPODERMIC NEEDLE 25G X 5/8" , 27G X 1/2" , 30G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH INSULIN SYRINGE 27G X 5/8" 1 ML (*insulin syringe-needle u-100*)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH PEN NEEDLES 30G X 5 MM , 30G X 8 MM , 32G X 5 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH SAFETY PEN NEEDLES 29G X 5MM , 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
EASY TOUCH SAFETY SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
EASY TOUCH SHEATHLOCK SYRINGE 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
EASY TOUCH SYRINGE BARREL 10ML (*needles & syringes*)	Preferred	
EASY TOUCH SYRINGE BARREL 1ML (*needles & syringes*)	Preferred	
EASY TOUCH SYRINGE BARREL 3ML (*needles & syringes*)	Preferred	
EASY TOUCH SYRINGE BARREL 5ML (*needles & syringes*)	Preferred	
EASY TOUCH TB FLIPLOCK SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
EASY TOUCH TB SHEATHLOCK SYR 25G X 5/8" 1 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
EASYPOINT NEEDLE 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" (*needle (disp)*)	Preferred	
EASYPOINT NEEDLE 25G X 5/8" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
EASYPOINT NEEDLE/SYRINGE 18G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
EMBRACE PEN NEEDLES 30G X 5 MM , 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
H-E-B INCONTROL UNIFINE PENTIP 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
LUER LOCK SAFETY SYRINGES 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
MAGELLAN TUBERCULIN SYRINGE 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
MAXI-COMFORT SAFETY PEN NEEDLE 29G X 5MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
MICRODOT PEN NEEDLE 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT FILTER ASPIRATOR (*needles & syringes*)	Preferred	
MONOJECT HYPODERMIC NEEDLE 16G X 1" , 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" , 25G X 1-1/2" , 27G X 1-1/2" (*needle (disp)*)	Preferred	
MONOJECT HYPODERMIC NEEDLE 25G X 5/8" , 27G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT INSULIN SYRINGE 25G X 5/8" 1 ML (*insulin syringe-needle u-100*)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT INSULIN SYRINGE U-100 1 ML (*insulin syringes (disposable)*)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT MAGELLAN SAFETY NDL 18G X 1" , 18G X 1-1/2" , 20G X 1" , 22G X 1" , 22G X 1-1/2" , 23G X 1" , 25G X 1" (*needle (disp)*)	Preferred	
MONOJECT MAGELLAN SAFETY NDL 25G X 5/8" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
MONOJECT MAGELLAN SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
MONOJECT PHARMACY TRAY 1 ML (*syringe (disposable)*)	Preferred	
MONOJECT SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 25G X 1" 3 ML, 25G X 5/8" 3 ML, 27G X 1-1/4" 3 ML (*syringe/needle (disp)*)	Preferred	
MONOJECT SYRINGE 27G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
MONOJECT SYRINGE PHARMACY TRAY 1 ML (*syringe (disposable)*)	Preferred	
MONOJECT TB SAFETY SYRINGE 25G X 5/8" 1 ML, 28G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
MONOJECT TB SYRINGE 1 ML (*syringe (disposable)*)	Preferred	
MONOJECT TB SYRINGE 25G X 5/8" 1 ML, 27G X 1/2" 1 ML, 28G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
NOKOR VENTED NEEDLE 18G X 1" (*needle (disp)*)	Preferred	
NORM-JECT LUER SLIP SYRINGE 1 ML (*syringe (disposable)*)	Preferred	
PERFECT POINT SAFETY NEEDLE 25G X 1" (*needle (disp)*)	Preferred	
SECURESAFE HYPODERMIC NEEDLE 22G X 1" , 25G X 1-1/2" (*needle (disp)*)	Preferred	
SECURESAFE HYPODERMIC NEEDLE 27G X 1/2" (*needle (disp)*)	Preferred	90-day fill allowed after two 1-month fills
SECURESAFE SAFETY PEN NEEDLES 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
SECURESAFE SYRINGE/NEEDLE 20G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
TECHLITE PEN NEEDLES 29G X 10MM , 29G X 12MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM , 32G X 6 MM , 32G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
TECHLITE PLUS PEN NEEDLES 32G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
TRUEPLUS 5-BEVEL PEN NEEDLES 29G X 12.7MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
TRUEPLUS INSULIN SYRINGE 28G X 1/2" 0.5 ML, 28G X 1/2" 1 ML, 29G X 1/2" 0.3 ML, 29G X 1/2" 0.5 ML, 29G X 1/2" 1 ML, 30G X 5/16" 0.3 ML, 30G X 5/16" 0.5 ML, 30G X 5/16" 1 ML, 31G X 5/16" 0.3 ML, 31G X 5/16" 0.5 ML, 31G X 5/16" 1 ML (*insulin syringe-needle u-100*)	Preferred	90-day fill allowed after two 1-month fills
TRUEPLUS PEN NEEDLES 29G X 12MM , 31G X 5 MM , 31G X 6 MM , 31G X 8 MM , 32G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE INSULIN SYR 1/2 UNIT 31G X 1/4" 0.3 ML (*insulin syringe-needle u-100*)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE INSULIN SYRINGE 31G X 1/4" 0.3 ML (*insulin syringe-needle u-100*)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE MINI PEN NEEDLES 30G X 5 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE SHORT PEN NEEDLES 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
ULTICARE SYRINGE 22G X 1-1/2" 3 ML (*syringe/needle (disp)*)	Preferred	
ULTICARE TUBERCULIN SAFETY SYR 25G X 1" 1 ML, 25G X 5/8" 1 ML (*tuberculin-allergy syringes*)	Preferred	
ULTRA FLO INSULIN PEN NEEDLES 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE PENTIPS 30G X 5 MM , 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE PENTIPS PLUS 30G X 5 MM , 33G X 4 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE PROTECT PEN NEEDLE 30G X 5 MM , 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
UNIFINE SAFECONTROL PEN NEEDLE 30G X 5 MM , 30G X 8 MM (*insulin pen needle*)	Preferred	90-day fill allowed after two 1-month fills
VANISHPOINT SAFETY SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	
VANISHPOINT SYRINGE 20G X 1" 3 ML, 21G X 1" 3 ML, 21G X 1-1/2" 3 ML, 22G X 1" 3 ML, 22G X 1-1/2" 3 ML, 23G X 1" 3 ML, 23G X 1-1/2" 3 ML, 25G X 1" 3 ML, 25G X 1-1/2" 3 ML, 25G X 5/8" 3 ML (*syringe/needle (disp)*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
VANISHPOINT TUBERCULIN SYRINGE 25G X 1" 1 ML, 25G X 5/8" 1 ML, 27G X 1/2" 1 ML (*tuberculin-allergy syringes*)	Preferred	
NIT REMOVERS**		
LYCELLE EXTERNAL GEL (*nit remover*)	Preferred	
NITRATES**		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	Preferred	QL (12 EA per 1 day); 90-day fill allowed after two 1-month fills
isosorbide mononitrate er oral tablet extended release 24 hour 120 mg, 30 mg, 60 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
isosorbide mononitrate oral tablet 10 mg, 20 mg	Preferred	QL (2 EA per 1 day); 90-day fill allowed after two 1-month fills
nitroglycerin sublingual tablet sublingual 0.3 mg, 0.4 mg	Preferred	QL (6 EA per 1 day)
nitroglycerin transdermal patch 24 hour 0.1 mg/hr, 0.2 mg/hr	Preferred	QL (1 EA per 1 day); 90-day fill allowed after two 1-month fills
NITRO-BID TRANSDERMAL OINTMENT 2 % (*nitroglycerin*)	Preferred	QL (4 GM per 1 day); 90-day fill allowed after two 1-month fills
NITROGEN MUSTARDS AND RELATED ANALOGUES**		
cyclophosphamide oral capsule 25 mg, 50 mg	Preferred	SP; PA
NON-NARC ANTITUSSIVE-ANTIHISTAMINE**		
cough & cold hbp oral tablet 4-30 mg	Preferred	
cough & cold oral tablet 4-30 mg	Preferred	
dextromethorphan-pyrilamine oral liquid 7.5-7.5 mg/5ml	Preferred	
gnp cough & cold hbp oral tablet 4-30 mg	Preferred	
gnp night time cough oral liquid 6.25-15 mg/15ml	Preferred	
goodsense night time cough oral liquid 6.25-15 mg/15ml	Preferred	
promethazine-dm oral syrup 6.25-15 mg/5ml	Preferred	AGE (Min 2 Years)
sm cough/runny nose childrens oral liquid 1-5 mg/5ml	Preferred	
CORICIDIN HBP COUGH/COLD ORAL TABLET 4-30 MG (*chlorpheniramine-dm*)	Preferred	
NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE**		
cold & cough childrens oral liquid 1-5-2.5 mg/5ml	Preferred	
cold/cough childrens oral liquid 2.5-1-5 mg/5ml	Preferred	
ed-a-hist dm oral liquid 10-4-15 mg/5ml	Preferred	
ft cold & cough relief dm oral liquid 2.5-1-5 mg/5ml	Preferred	
gnp cold/cough childrens oral liquid 2.5-1-5 mg/5ml	Preferred	
hm cold & cough childrens oral liquid 2.5-1-5 mg/5ml	Preferred	
lohist-dm oral syrup 5-2-10 mg/5ml	Preferred	

Drug Name	Formulary Status	Requirements/Limits
nohist-dm oral liquid 10-4-15 mg/5ml	Preferred	
pseudoeph-bromphen-dm oral syrup 30-2-10 mg/5ml	Preferred	AGE (Min 2 Years)
rynex dm oral liquid 2.5-1-5 mg/5ml	Preferred	
sm cold & cough childrens oral liquid 2.5-1-5 mg/5ml	Preferred	
DIMAPHEN DM COLD/COUGH ORAL LIQUID 2.5-1-5 MG/5ML (*phenylephrine-bromphen-dm*)	Preferred	
ENDACOF-DM ORAL LIQUID 2.5-1-5 MG/5ML (*phenylephrine-bromphen-dm*)	Preferred	
NON-NARC ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE-ANALG**		
ft cold & flu nighttime severe oral liquid 5-6.25-10-325 mg/15ml	Preferred	
goodsense nighttime cold & flu oral liquid 5-6.25-10-325 mg/15ml	Preferred	
sm cold head congestion night oral tablet 5-2-10-325 mg	Preferred	
sm nite time cold & flu oral liquid 5-6.25-10-325 mg/15ml	Preferred	
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)**		
sm ibuprofen jr oral tablet 100 mg	Preferred	
NUTRITIONAL SUPPLEMENTS**		
thrivacin 30 oral liquid	Preferred	
thrivacin detox oral liquid	Preferred	
SM NUTRI-DRINK + ORAL LIQUID (*nutritional supplements*)	Preferred	
SM NUTRI-DRINK ORAL LIQUID (*nutritional supplements*)	Preferred	
OPHTHALMIC DECONGESTANT COMBINATIONS**		
gnp eye drops ophthalmic solution 0.05-0.25 %	Preferred	
OPHTHALMIC DECONGESTANTS**		
eye drops ophthalmic solution 0.05 %	Preferred	
ft eye drops ophthalmic solution 0.05 %	Preferred	
gnp eye drops ophthalmic solution 0.05 %	Preferred	
sm eye drops ophthalmic solution 0.05 %	Preferred	
OPHTHALMIC HYPEROSMOLAR PRODUCTS**		
sodium chloride (hypertonic) ophthalmic ointment 5 %	Preferred	
sodium chloride (hypertonic) ophthalmic solution 5 %	Preferred	
MURO 128 OPHTHALMIC SOLUTION 2 % (*sodium chloride (hypertonic)*)	Preferred	
OPHTHALMIC IRRIGATION SOLUTIONS**		
eye wash ophthalmic solution	Preferred	
sm eye wash ophthalmic solution 0.002 %	Preferred	
EYE STREAM OPHTHALMIC SOLUTION (*ophth irr soln-extraocular*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
OPHTHALMIC LOCAL ANESTHETICS**		
proparacaine hcl ophthalmic solution 0.5 %	Preferred	
OPIOID ANTITUSSIVE-DECONGESTANT-ANTIHISTAMINE**		
capcof oral syrup 5-2-10 mg/5ml	Preferred	
ORAL VEHICLES**		
simple syrup oral syrup	Preferred	
sorbitol solution , 70 %	Preferred	
MX-SOL BLEND ORAL SUSPENSION (*oral vehicles*)	Preferred	
MX-SOL BLEND SF ORAL SUSPENSION (*oral vehicles*)	Preferred	
MX-SOL ORAL SYRUP (*oral vehicles*)	Preferred	
MX-SOL SF ORAL SYRUP (*oral vehicles*)	Preferred	
MX-SOL SUSPEND ORAL SUSPENSION (*oral vehicles*)	Preferred	
ORA-BLEND ORAL SUSPENSION (*oral vehicles*)	Preferred	
ORA-BLEND SF ORAL SUSPENSION (*oral vehicles*)	Preferred	
ORA-PLUS ORAL LIQUID (*oral vehicles*)	Preferred	
ORA-SWEET ORAL SYRUP (*oral vehicles*)	Preferred	
ORA-SWEET SF ORAL SYRUP (*oral vehicles*)	Preferred	
SOSWEET ORAL SYRUP (*oral vehicles*)	Preferred	
OTIC AGENTS - MISCELLANEOUS**		
acetic acid otic solution 2 %	Preferred	
ear drops otic solution 6.5 %	Preferred	
earwax removal otic solution 6.5 %	Preferred	
ft earwax removal kit otic solution 6.5 %	Preferred	
ft earwax removal otic solution 6.5 %	Preferred	
gnp earwax removal drops otic solution 6.5 %	Preferred	
gnp earwax removal kit otic solution 6.5 %	Preferred	
sm ear drops otic solution 6.5 %	Preferred	
OTIC STEROIDS**		
hydrocortisone-acetic acid otic solution 1-2 %	Preferred	
OXAZOLIDINONES**		
linezolid oral tablet 600 mg	Preferred	QL (2 EA per 1 day)
OXYTOCICS**		
methylergonovine maleate oral tablet 0.2 mg	Preferred	QL (6 EA per 1 day)
methylergonovine maleate (Methergine Oral Tablet 0.2 Mg)	Preferred	QL (6 EA per 1 day)
PARENTERAL VEHICLES**		
sterile water for injection injection solution	Preferred	
PEAK FLOW METERS**		
breathe ease peak flow meter device	Preferred	
lung perform peak flow meter device	Preferred	

Drug Name	Formulary Status	Requirements/Limits
peak a-i-r flow meter device	Preferred	
peak flow meter universal rang device	Preferred	
pure comfort flow meter adult device	Preferred	
pure comfort flow meter child device	Preferred	
AIRZONE PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
ASSESS PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
CLEVER CHOICE PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
MICROLIFE DIGITAL PEAK FLOW DEVICE (*peak flow meter*)	Preferred	
MINI WRIGHT PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
PEAK AIR PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
PERSONAL BEST FULL RANGE DEVICE (*peak flow meter*)	Preferred	
PIKO 1 DEVICE (*peak flow meter*)	Preferred	
POCKET PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
POCKETPEAK PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
STRIVE DUAL ZONE PEAK FLOW MTR DEVICE (*peak flow meter*)	Preferred	
TRUZONE PEAK FLOW METER DEVICE (*peak flow meter*)	Preferred	
PED MV W/ FLUORIDE**		
multivitamin w/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	Preferred	
multivitamin/fluoride oral solution 0.25 mg/ml	Preferred	
multi-vitamin/fluoride oral solution 0.25 mg/ml	Preferred	
multivitamin/fluoride oral tablet chewable 0.25 mg, 0.5 mg, 1 mg	Preferred	
FLORAFOL PEDIATRIC ORAL TABLET CHEWABLE 0.5 MG, 1 MG (*pediatric multivitamins-fl*)	Preferred	
FLORIVA PLUS ORAL SOLUTION 0.25 MG/ML (*pediatric multivitamins-fl*)	Preferred	
MULTI-VIT-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (*pediatric multivitamins-fl*)	Preferred	
POLY-VI-FLOR ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (*pediatric multivitamins-fl*)	Preferred	
QUFLORA PEDIATRIC ORAL SOLUTION 0.25 MG/ML (*pediatric multivitamins-fl*)	Preferred	
QUFLORA PEDIATRIC ORAL TABLET CHEWABLE 0.25 MG, 0.5 MG, 1 MG (*pediatric multivitamins-fl*)	Preferred	
SOLUVITA WITH FLUORIDE ORAL SOLUTION 0.25 MG/ML (*pediatric multivitamins-fl*)	Preferred	
PED MV W/ IRON**		
gnp childrens chewables/iron oral tablet chewable 15 mg	Preferred	
multivitamin infant & toddler oral solution 11 mg/ml	Preferred	
sm animal shapes complete oral tablet chewable 18 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
CEROVITE JR ORAL TABLET CHEWABLE 18 MG (*pediatric multivitamins-iron*)	Preferred	
PEDIATRIC MULTIPLE VITAMINS**		
gnp childrens chewables/ex c oral tablet chewable	Preferred	
gnp little ones childrens oral tablet chewable	Preferred	
multivitamin infant & toddler oral solution	Preferred	
sm animal shapes kids first oral tablet chewable	Preferred	
PENICILLIN COMBINATIONS**		
amoxicillin-pot clavulanate oral suspension reconstituted 200-28.5 mg/5ml, 400-57 mg/5ml, 600-42.9 mg/5ml	Preferred	
amoxicillin-pot clavulanate oral tablet 250-125 mg, 500-125 mg, 875-125 mg	Preferred	
amoxicillin-pot clavulanate oral tablet chewable 400-57 mg	Preferred	
PENICILLINASE-RESISTANT PENICILLINS**		
dicloxacillin sodium oral capsule 250 mg, 500 mg	Preferred	
PHOSPHATE**		
phosphorous oral tablet 155-852-130 mg	Preferred	
phosphorus supplement oral packet 280-160-250 mg	Preferred	
wes-phos 250 neutral oral tablet 155-852-130 mg	Preferred	
k phos mono-sod phos di & mono (Phospha 250 Neutral Oral Tablet 155-852-130 Mg)	Preferred	
k phos mono-sod phos di & mono (Phospho-Trin 250 Neutral Oral Tablet 155-852-130 Mg)	Preferred	
potassium phosphate monobasic (Phospho-Trin K500 Oral Tablet 500 Mg)	Preferred	
PHOSPHODIESTERASE III INHIBITORS**		
cilostazol oral tablet 100 mg, 50 mg	Preferred	QL (2 EA per 1 day)
POTASSIUM REMOVING AGENTS**		
sodium polystyrene sulfonate oral powder	Preferred	
POTASSIUM SPARING DIURETICS**		
amiloride hcl oral tablet 5 mg	Preferred	
spironolactone oral tablet 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
POTASSIUM**		
potassium chloride crys er oral tablet extended release 10 meq	Preferred	
potassium chloride crys er oral tablet extended release 20 meq	Preferred	90-day fill allowed after two 1-month fills
potassium chloride er oral capsule extended release 10 meq, 8 meq	Preferred	90-day fill allowed after two 1-month fills
potassium chloride er oral tablet extended release 10 meq, 8 meq	Preferred	90-day fill allowed after two 1-month fills
potassium chloride er oral tablet extended release 20 meq	Preferred	
potassium chloride oral solution 10 %, 20 meq/15ml (10%)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
potassium chloride oral solution 40 meq/15ml (20%)	Preferred	90-day fill allowed after two 1-month fills
potassium bicarbonate (Effer-K Oral Tablet Effervescent 25 Meq)	Preferred	
potassium chloride (Klor-Con 10 Oral Tablet Extended Release 10 Meq)	Preferred	90-day fill allowed after two 1-month fills
potassium chloride crys er (Klor-Con M10 Oral Tablet Extended Release 10 Meq)	Preferred	
potassium chloride crys er (Klor-Con M20 Oral Tablet Extended Release 20 Meq)	Preferred	90-day fill allowed after two 1-month fills
potassium chloride (Klor-Con Oral Tablet Extended Release 8 Meq)	Preferred	90-day fill allowed after two 1-month fills
potassium bicarbonate (Klor-Con/Ef Oral Tablet Effervescent 25 Meq)	Preferred	
PRENATAL MV & MIN W/FE-FA**		
classic prenatal oral tablet 28-0.8 mg	Preferred	
completenate oral tablet chewable 29-1 mg	Preferred	
gnp prenatal oral tablet 28-0.8 mg	Preferred	
m-natal plus oral tablet 27-1 mg	Preferred	
prenatal oral tablet 27-0.8 mg, 27-1 mg	Preferred	
prenatal plus oral tablet 27-1 mg	Preferred	
prenatal plus vitamin/mineral oral tablet 27-1 mg	Preferred	
prenatal vitamins oral tablet 28-0.8 mg	Preferred	
se-natal 19 oral tablet 29-1 mg	Preferred	
se-natal 19 oral tablet chewable 29-1 mg	Preferred	
sm prenatal vitamins oral tablet 28-0.8 mg	Preferred	
thrivite rx oral tablet 29-1 mg	Preferred	
trinatal rx 1 oral tablet 60-1 mg	Preferred	
westab plus oral tablet 27-1 mg	Preferred	
NIVA-PLUS ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	Preferred	
PRENATRIX ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	Preferred	
PRENATRYL ORAL TABLET 27-1 MG (*prenatal vit-fe fumarate-fa*)	Preferred	
TRICARE ORAL TABLET (*prenatal vit-fe fumarate-fa*)	Preferred	
VITAFOL-OB ORAL TABLET (*prenatal vit-fe fumarate-fa*)	Preferred	
PRENATAL MV & MIN W/FE-FA-DHA**		
STUART ONE ORAL CAPSULE 27-0.8-200 MG (*prenatal mv-min-fe cbn-fa-dha*)	Preferred	
PROGESTIN CONTRACEPTIVES - ORAL**		
norethindrone oral tablet 0.35 mg	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
norethindrone (Camila Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Deblitane Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Emzahh Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Errin Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Heather Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Incassia Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Jencycla Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Lyleq Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Lyza Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Nora-Be Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Norlyroc Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
norethindrone (Sharobel Oral Tablet 0.35 Mg)	Preferred	Max 365-day supply per 1 Fill
PSEUDOBULBAR AFFECT AGENT COMBINATIONS**		
NUEDEXTA ORAL CAPSULE 20-10 MG (*dextromethorphan-quinidine*)	Preferred	PA
PURINE ANALOGS**		
azathioprine oral tablet 50 mg	Preferred	90-day fill allowed after two 1-month fills
PYRIMIDINE SYNTHESIS INHIBITORS**		
leflunomide oral tablet 10 mg, 20 mg	Preferred	
QUATERNARY ANTICHOLINERGICS**		
glycopyrrolate oral tablet 1 mg, 2 mg	Preferred	
RECTAL ANESTHETIC COMBINATIONS**		
hemorrhoidal external cream 1-0.25-14.4-15 %	Preferred	
RECTAL COMBINATIONS - MISC.**		
ft hemorrhoidal rectal ointment 0.25-14-74.9 %	Preferred	
gnp hemorrhoidal rectal ointment 0.25-14-74.9 %	Preferred	
goodsense hemorrhoidal rectal ointment 0.25-14-74.9 %	Preferred	
goodsense hemorrhoidal rectal suppository 0.25-88.44 %	Preferred	
hemorrhoidal rectal ointment 0.25-14-74.9 %	Preferred	
hemorrhoidal rectal suppository 0.25-88.44 %	Preferred	
sm hemorrhoidal cooling external gel 0.25-50 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
sm hemorrhoidal rectal ointment 0.25-14-74.9 %	Preferred	
RECTAL LOCAL ANESTHETICS**		
gnp anorectal external cream 5 %	Preferred	
lidocaine (anorectal) external cream 5 %	Preferred	
numbcream external cream 5 %	Preferred	
pramoxine hcl (perianal) external foam 1 %	Preferred	
RECTASMOOTHE EXTERNAL CREAM 5 % (*lidocaine (anorectal)*)	Preferred	
RESPIRATORY THERAPY SUPPLIES**		
adult aerosol mask	Preferred	
adult disposable mouthpiece	Preferred	
adult mask device	Preferred	
adult mask large	Preferred	
breathe ease neb mask/child	Preferred	
breathe ease neb mask/infant	Preferred	
co monitor device	Preferred	
co monitor replacement pieces	Preferred	
disposable full range mouthpiece	Preferred	
disposable low range mouthpiece	Preferred	
disposable low range/pediatric mouthpiece	Preferred	
disposable paper mouthpiece	Preferred	
disposable universal range mouthpiece	Preferred	
expiratory mouthpiece	Preferred	
filter air pp	Preferred	
full kit nebulizer set	Preferred	
nebulizer air tube/plugs	Preferred	
nebulizer cup/tubing device	Preferred	
nebulizer mask adult	Preferred	
nebulizer mask child	Preferred	
nose clip	Preferred	
one-way valved expiratory mouthpiece	Preferred	
one-way valved inspiratory mouthpiece	Preferred	
ped disposable mouthpiece	Preferred	
pediatric mouthpiece	Preferred	
pharmacist choice mask wipes	Preferred	
pillow mask/adult	Preferred	
pillow mask/child	Preferred	
pillow mask/pediatric	Preferred	
pure comfort 3-ball breathe ex device	Preferred	
replacement air filter	Preferred	
replacement filters	Preferred	

Drug Name	Formulary Status	Requirements/Limits
silicone mask/adult	Preferred	
silicone mask/infant	Preferred	
silicone mask/pediatric	Preferred	
sootheneb nbl 100 adult mask	Preferred	
sootheneb nbl 100 child mask	Preferred	
sootheneb nbl 100 med cup	Preferred	
sootheneb nbl 100 mesh cap	Preferred	
spiro pd device	Preferred	
tubing/wing tip	Preferred	
ultra neb accessories kit	Preferred	
ACE AEROSOL CLOUD ENHANCER (*respiratory therapy supplies*)	Preferred	
ACTIVITY POUCH (*respiratory therapy supplies*)	Preferred	
ADAPTER PED DISPOSABLE MOUTHPIECE (*respiratory therapy supplies*)	Preferred	
AEROBIKA DEVICE (*respiratory therapy supplies*)	Preferred	
AEROECLIPSE EZ TWIST TUBING (*respiratory therapy supplies*)	Preferred	
AEROECLIPSE MASK LARGE (*respiratory therapy supplies*)	Preferred	
AEROECLIPSE MASK MEDIUM (*respiratory therapy supplies*)	Preferred	
AEROECLIPSE MASK SMALL (*respiratory therapy supplies*)	Preferred	
AEROTRACH PLUS (*respiratory therapy supplies*)	Preferred	
AIRS PEDIATRIC AEROSOL MASK (*respiratory therapy supplies*)	Preferred	
ALL FLOW 1000 PFT FILTER (*respiratory therapy supplies*)	Preferred	
ALL FLOW 1000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
ALL FLOW 2000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
ALL FLOW 3000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
ALL FLOW 4000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
ALL FLOW 5000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
ALL FLOW 6000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
ALL FLOW 7000 PFT FILTER DEVICE (*respiratory therapy supplies*)	Preferred	
BUBBLES THE FISH II PEDI MASK (*respiratory therapy supplies*)	Preferred	
CARETOUCH 2 CPAP HOSE HANGER (*respiratory therapy supplies*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
CARETOUCH CPAP & BIPAP HOSE (*respiratory therapy supplies*)	Preferred	
CARETOUCH CPAP MASK WIPES (*respiratory therapy supplies*)	Preferred	
CARETOUCH CPAP PRE-WASH SOLN (*respiratory therapy supplies*)	Preferred	
CARETOUCH CPAP TUBE BRUSH (*respiratory therapy supplies*)	Preferred	
CARETOUCH UNIVERSL CPAP FILTER (*respiratory therapy supplies*)	Preferred	
EASY FLOW 300 MM HOSE (*respiratory therapy supplies*)	Preferred	
EASY FLOW 400 MM HOSE (*respiratory therapy supplies*)	Preferred	
EASY FLOW AIR NOZZLE (*respiratory therapy supplies*)	Preferred	
EASY FLOW BLACK/BLUE DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW BLACK/ORANGE DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW BLACK/RED DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW BLACK/WHITE DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW BLACK/YELLOW DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW HEPA FILTER (*respiratory therapy supplies*)	Preferred	
EASY FLOW WHITE/BLUE DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW WHITE/GREEN DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW WHITE/PINK DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW WHITE/WHITE DEVICE (*respiratory therapy supplies*)	Preferred	
EASY FLOW WHITE/YELLOW DEVICE (*respiratory therapy supplies*)	Preferred	
EBASE CONTROLLER KIT (*respiratory therapy supplies*)	Preferred	
FLYP HYPERSONIQ CARTRIDGE (*respiratory therapy supplies*)	Preferred	
IN-CHECK DIAL FLOW TRAINER DEVICE (*respiratory therapy supplies*)	Preferred	
IN-CHECK INSPIRATORY FLOW MTR DEVICE (*respiratory therapy supplies*)	Preferred	
INNOSPIRE REPLACEMENT FILTER (*respiratory therapy supplies*)	Preferred	
KOKO PEAK PRO MOUTHPIECE (*respiratory therapy supplies*)	Preferred	
LITETOUCH MASK LARGE (*respiratory therapy supplies*)	Preferred	
LITETOUCH MASK MEDIUM (*respiratory therapy supplies*)	Preferred	
LITETOUCH MASK SMALL (*respiratory therapy supplies*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
MINIELITE FILTER REPLACEMENTS (*respiratory therapy supplies*)	Preferred	
OMBRA COMPRESSOR AIR FILTERS (*respiratory therapy supplies*)	Preferred	
OMBRA TABLE TOP COMPRESSOR DEVICE (*respiratory therapy supplies*)	Preferred	
ONE FLOW SPIROMETER DEVICE (*respiratory therapy supplies*)	Preferred	
ONE FLOW TESTER MOUTHPIECE (*respiratory therapy supplies*)	Preferred	
PARI ALTERA NEBULIZER HANDSET (*respiratory therapy supplies*)	Preferred	
PARI BABY CONVERSION KIT (*respiratory therapy supplies*)	Preferred	
PARI BUBBLES PEDIATRIC MASK (*respiratory therapy supplies*)	Preferred	
PARI ERAPID NEBULIZER HANDSET (*respiratory therapy supplies*)	Preferred	
PARI EXPIRATORY FILTER SET DEVICE (*respiratory therapy supplies*)	Preferred	
PARI MANUAL INTERRUPTER DEVICE (*respiratory therapy supplies*)	Preferred	
PARI MASK SET (*respiratory therapy supplies*)	Preferred	
PARI SMARTMASK BABY/ELBOW (*respiratory therapy supplies*)	Preferred	
PARI SOFT PLASTIC ADULT MASK (*respiratory therapy supplies*)	Preferred	
PARI SOFT PLASTIC PED MASK (*respiratory therapy supplies*)	Preferred	
PARI TREK S COMBO PACK DEVICE (*respiratory therapy supplies*)	Preferred	
PFLEX (*respiratory therapy supplies*)	Preferred	
PRONEB ULTRA FILTER SET (*respiratory therapy supplies*)	Preferred	
QUAKE DEVICE (*respiratory therapy supplies*)	Preferred	
REUSABLE COMFORTSEAL MASK-LRG (*respiratory therapy supplies*)	Preferred	
REUSABLE COMFORTSEAL MASK-MED (*respiratory therapy supplies*)	Preferred	
REUSABLE COMFORTSEAL MASK-SML (*respiratory therapy supplies*)	Preferred	
SAMI THE SEAL FILTERS (*respiratory therapy supplies*)	Preferred	
SIDESTREAM ADULT FACE MASK (*respiratory therapy supplies*)	Preferred	
SIDESTREAM PEDIATRIC FACE MASK (*respiratory therapy supplies*)	Preferred	
SIDESTREAM PLS ADULT FACE MASK (*respiratory therapy supplies*)	Preferred	
THRESHOLD IMT (*respiratory therapy supplies*)	Preferred	
THRESHOLD PEP DEVICE (*respiratory therapy supplies*)	Preferred	
VERSAPAP DEVICE (*respiratory therapy supplies*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
VERSAPAP W/UNIVERSAL TUBING DEVICE (*respiratory therapy supplies*)	Preferred	
WINDMILL TRAINER (*respiratory therapy supplies*)	Preferred	
RETINOIDS**		
tretinoin oral capsule 10 mg	Preferred	PA; QL (90 EA per 365 days)
SALICYLATE COMBINATIONS**		
effervescent antacid/pain rel oral tablet effervescent 500 mg	Preferred	
sm aspirin tri-buffered oral tablet 325 mg	Preferred	
sm effervescent pain relief oral tablet effervescent 325-1000-1916 mg	Preferred	
tri-buffered aspirin oral tablet 325 mg	Preferred	
SALICYLATES**		
aspirin low dose oral tablet chewable 81 mg	Preferred	
aspirin low dose oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
aspirin oral tablet 325 mg	Preferred	
aspirin oral tablet chewable 81 mg	Preferred	
aspirin oral tablet delayed release 325 mg	Preferred	
aspirin oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
aspirin rectal suppository 300 mg	Preferred	
aspirin regimen oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
ft aspirin low dose oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
ft aspirin oral tablet 325 mg	Preferred	
ft aspirin oral tablet chewable 81 mg	Preferred	
ft enteric coated aspirin oral tablet delayed release 325 mg	Preferred	
gnp adult aspirin low strength oral tablet chewable 81 mg	Preferred	
gnp aspirin low dose oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
gnp aspirin oral tablet 325 mg	Preferred	
gnp aspirin oral tablet delayed release 325 mg	Preferred	
gnp aspirin oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
goodsense aspirin adults oral tablet 325 mg	Preferred	
goodsense aspirin low dose oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
goodsense aspirin oral tablet 325 mg	Preferred	
goodsense aspirin oral tablet chewable 81 mg	Preferred	
hm adult aspirin oral tablet 325 mg	Preferred	
sm aspirin adult low strength oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
sm aspirin ec low strength oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
sm aspirin ec oral tablet delayed release 325 mg	Preferred	
sm aspirin low dose oral tablet chewable 81 mg	Preferred	
sm aspirin low dose oral tablet delayed release 81 mg	Preferred	90-day fill allowed after two 1-month fills
sm childrens aspirin oral tablet chewable 81 mg	Preferred	
SALINE LAXATIVE MIXTURES**		
enema ready-to-use rectal enema 7-19 gm/118ml	Preferred	
enema rectal enema 7-19 gm/118ml	Preferred	
ft enema saline rectal enema 7-19 gm/118ml	Preferred	
hm enema rectal enema 7-19 gm/118ml	Preferred	
sm enema rectal enema , 7-19 gm/118ml	Preferred	
SALINE LAXATIVES**		
cvs epsom salt granules	Preferred	
epsom salt granules	Preferred	
epsom salt oral granules	Preferred	
eql epsom salt granules	Preferred	
ft epsom salt oral granules	Preferred	
ft magnesium citrate oral solution 1.745 gm/30ml	Preferred	
ft milk of magnesia oral suspension 1200 mg/15ml	Preferred	
gnp epsom salt oral granules	Preferred	
gnp magnesium citrate oral solution 1.745 gm/30ml	Preferred	
gnp milk of magnesia oral suspension 1200 mg/15ml	Preferred	
hm milk of magnesia oral suspension 1200 mg/15ml	Preferred	
magnesium citrate oral solution 1.745 gm/30ml	Preferred	
milk of magnesia concentrate oral suspension 2400 mg/10ml	Preferred	
milk of magnesia oral suspension 1200 mg/15ml, 2400 mg/30ml, 400 mg/5ml, 7.75 %	Preferred	
ra epsom salt granules	Preferred	
sm epsom salt oral granules	Preferred	
sm milk of magnesia oral suspension 1200 mg/15ml	Preferred	
PEDIA-LAX ORAL TABLET CHEWABLE 400 MG (*magnesium hydroxide*)	Preferred	
SCABICIDE COMBINATIONS**		
ft lice killing max st external shampoo 0.33-4 %	Preferred	
gnp lice killing external shampoo 0.33-4 %	Preferred	
gnp lice treatment external shampoo 0.33-4 %	Preferred	
lice killing external shampoo 0.33-4 %	Preferred	
lice killing maximum strength external shampoo 0.33-4 %	Preferred	
lice killing shampoo max str external shampoo 0.33-4 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
sm lice killing external shampoo 0.33-4 %	Preferred	
sm lice killing max strength external shampoo 0.33-4 %	Preferred	
SCABICIDES & PEDICULICIDES**		
gnp lice treatment external liquid 1 %	Preferred	
goodsense lice killing external liquid 1 %	Preferred	
ivermectin external lotion 0.5 %	Preferred	
permethrin external cream 5 %	Preferred	
sm lice treatment external liquid 1 %	Preferred	
SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS)**		
OSPHENA ORAL TABLET 60 MG (*ospemifene*)	Preferred	QL (1 EA per 1 day)
SEMI SOLID VEHICLES**		
baby skin protectant external ointment 41 %	Preferred	
cvs petroleum jelly external gel	Preferred	
daily moisturizer external ointment 41 %	Preferred	
ft petroleum jelly external gel	Preferred	
gnp petroleum jelly external gel	Preferred	
goodsense petroleum jelly external gel	Preferred	
hm petroleum jelly external gel	Preferred	
petrolatum external gel	Preferred	
petrolatum external ointment 42 %	Preferred	
petrolatum white external gel	Preferred	
petroleum jelly external gel , 100 %	Preferred	
qc petroleum jelly external gel 100 %, 99.89 %	Preferred	
sm petroleum jelly external gel	Preferred	
white petrolatum external gel	Preferred	
white petroleum jelly external gel	Preferred	
white petrolatum (Vaseline External Gel)	Preferred	
VASELINE PURE ULTRA WHITE EXTERNAL GEL (*white petrolatum*)	Preferred	
SKIN PROTECTANTS**		
ABSORBASE EXTERNAL OINTMENT (*skin protectants, misc.*)	Preferred	
MINERIN CREME EXTERNAL CREAM (*skin protectants, misc.*)	Preferred	
SOAPS**		
ACUWASH EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
AQUA GLYCOLIC FACIAL CLEANSER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
AQUA GLYCOLIC SHAMPOO/BODY EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
AQUA GLYCOLIC TONER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
PURPOSE GENTLE CLEANING WASH EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
REHYLA HAIR + BODY CLEANSER EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
REHYLA WASH EXTERNAL LIQUID (*soap & cleansers*)	Preferred	
SODIUM**		
sodium chloride oral tablet 1 gm	Preferred	
SOLIDS**		
butylated hydroxytoluene powder	Preferred	
SOMATOSTATIC AGENTS**		
octreotide acetate injection solution 100 mcg/ml	Preferred	SP; PA
SPACER/AEROSOL-HOLDING CHAMBERS & SUPPLIES**		
breathe comfort chamber/adult device	Preferred	
breathe comfort chamber/child device	Preferred	
breathe ease large device	Preferred	
breathe ease medium device	Preferred	
breathe ease small device	Preferred	
eq space chamber anti-static device	Preferred	
eq space chamber anti-static l device	Preferred	
eq space chamber anti-static m device	Preferred	
eq space chamber anti-static s device	Preferred	
pro comfort spacer adult	Preferred	
pro comfort spacer child	Preferred	
pro comfort spacer infant device	Preferred	
procare spacer/adult mask device	Preferred	
procare spacer/child mask device	Preferred	
prochamber vhc device	Preferred	
pure comfort spacer chamber device	Preferred	
AEROCHAMBER HOLDING CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER MINI CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER MV (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLS FLOVU MTHPIECE DEVICE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLO-VU INTERM DEVICE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLO-VU LARGE DEVICE (*spacer/aero-holding chambers*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
AEROCHAMBER PLUS FLO-VU MEDIUM (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLO-VU MEDIUM DEVICE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLO-VU SMALL DEVICE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER PLUS FLOW VU (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER W/FLOWSIGNAL (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER Z-STAT PLUS (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER Z-STAT PLUS CHAMBR (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER Z-STAT PLUS/LARGE (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER Z-STAT PLUS/MEDIUM (*spacer/aero-holding chambers*)	Preferred	
AEROCHAMBER Z-STAT PLUS/SMALL (*spacer/aero-holding chambers*)	Preferred	
AEROVENT PLUS DEVICE (*spacer/aero-holding chambers*)	Preferred	
BREATHERITE VALVED MDI CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
CLEVER CHOICE HOLDING CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
COMPACT SPACE CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
COMPACT SPACE CHAMBER/LG MASK DEVICE (*spacer/aero-holding chambers*)	Preferred	
COMPACT SPACE CHAMBER/MED MASK DEVICE (*spacer/aero-holding chambers*)	Preferred	
COMPACT SPACE CHAMBER/SM MASK DEVICE (*spacer/aero-holding chambers*)	Preferred	
EASIVENT (*spacer/aero-holding chambers*)	Preferred	
EASIVENT MASK LARGE (*spacer/aero-holding chambers*)	Preferred	
EASIVENT MASK MEDIUM (*spacer/aero-holding chambers*)	Preferred	
EASIVENT MASK SMALL (*spacer/aero-holding chambers*)	Preferred	
FLEXICHAMBER ADULT MASK/SMALL (*spacer/aero-hold chamber mask*)	Preferred	
FLEXICHAMBER CHILD MASK/LARGE (*spacer/aero-hold chamber mask*)	Preferred	
FLEXICHAMBER CHILD MASK/SMALL (*spacer/aero-hold chamber mask*)	Preferred	
FLEXICHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
INSPIREASE (*spacer/aero-holding chambers*)	Preferred	
MASK VORTEX/CHILD/FROG (*spacer/aero-hold chamber mask*)	Preferred	
MASK VORTEX/TODDLER/LADYBUG (*spacer/aero-hold chamber mask*)	Preferred	
MICROCHAMBER (*spacer/aero-holding chambers*)	Preferred	
MICROCHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
MICROSPACER (*spacer/aero-holding chambers*)	Preferred	
OPTICHAMBER DIAMOND (*spacer/aero-holding chambers*)	Preferred	
OPTICHAMBER DIAMOND DEVICE (*spacer/aero-holding chambers*)	Preferred	
OPTICHAMBER DIAMOND-LG MASK DEVICE (*spacer/aero-holding chambers*)	Preferred	
OPTICHAMBER DIAMOND-MD MASK (*spacer/aero-holding chambers*)	Preferred	
OPTICHAMBER DIAMOND-SM MASK (*spacer/aero-holding chambers*)	Preferred	
PANDA MASK LARGE (*spacer/aero-hold chamber mask*)	Preferred	
PANDA MASK MEDIUM (*spacer/aero-hold chamber mask*)	Preferred	
PANDA MASK SMALL (*spacer/aero-hold chamber mask*)	Preferred	
PARI VORTEX ADULT MASK (*spacer/aero-hold chamber mask*)	Preferred	
PEDIATRIC PANDA MASK (*spacer/aero-hold chamber mask*)	Preferred	
POCKET CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
POCKET SPACER DEVICE (*spacer/aero-holding chambers*)	Preferred	
RITEFLO DEVICE (*spacer/aero-holding chambers*)	Preferred	
VORTEX HOLD CHMBR/MASK/CHILD DEVICE (*spacer/aero-holding chambers*)	Preferred	
VORTEX HOLD CHMBR/MASK/TODDLER DEVICE (*spacer/aero-holding chambers*)	Preferred	
VORTEX VALVED HOLDING CHAMBER DEVICE (*spacer/aero-holding chambers*)	Preferred	
SPECIALTY VITAMINS PRODUCTS**		
urosex oral tablet	Preferred	
SPERMICIDES**		
OPTIONS GYNOL II CONTRACEPTIVE VAGINAL GEL 3 % (*nonoxynol-9*)	Preferred	
TODAY SPONGE VAGINAL 1000 MG (*nonoxynol-9*)	Preferred	
STIMULANT LAXATIVES**		
bisacodyl ec oral tablet delayed release 5 mg	Preferred	
bisacodyl rectal suppository 10 mg	Preferred	
castor oil oral oil 100 %	Preferred	
chocolated laxative oral tablet chewable 15 mg	Preferred	
ft castor oil oral oil 100 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
ft gentle laxative rectal suppository 10 mg	Preferred	
ft laxative oral tablet delayed release 5 mg	Preferred	
ft senna laxative oral tablet 8.6 mg	Preferred	
ft senna laxatives oral tablet 8.6 mg	Preferred	
gentle laxative oral tablet delayed release 5 mg	Preferred	
gentle laxative rectal suppository 10 mg	Preferred	
gnp castor oil oral oil 100 %	Preferred	
gnp gentle laxative oral tablet delayed release 5 mg	Preferred	
gnp gentle laxative rectal suppository 10 mg	Preferred	
gnp senna lax oral tablet 8.6 mg	Preferred	
gnp womens gentle laxative oral tablet delayed release 5 mg	Preferred	
laxative max str oral tablet 25 mg	Preferred	
laxative regular strength oral tablet 15 mg	Preferred	
senna oral capsule 8.6 mg	Preferred	
senna oral liquid 8.8 mg/5ml	Preferred	
senna oral syrup 176 mg/5ml, 8.8 mg/5ml	Preferred	
senna oral tablet 8.6 mg	Preferred	
senna-lax oral tablet 8.6 mg	Preferred	
senna-time oral tablet 8.6 mg	Preferred	
sm gentle laxative oral tablet delayed release 5 mg	Preferred	
sm laxative rectal suppository 10 mg	Preferred	
sm senna laxative oral tablet 8.6 mg	Preferred	
womens laxative oral tablet delayed release 5 mg	Preferred	
FLEET BISACODYL RECTAL ENEMA 10 MG/30ML (*bisacodyl*)	Preferred	
SENOKOT EXTRA STRENGTH ORAL TABLET 17.2 MG (*sennosides*)	Preferred	
SURFACTANT LAXATIVES**		
docusate calcium oral capsule 240 mg	Preferred	
docusate mini rectal enema 283 mg/5ml	Preferred	
docusate sodium oral capsule 100 mg, 250 mg	Preferred	
docusate sodium oral liquid 100 mg/10ml, 50 mg/5ml	Preferred	
ft stool softener oral capsule 100 mg, 250 mg	Preferred	
ft stool softener oral tablet 100 mg	Preferred	
gnp stool softener oral capsule 100 mg, 240 mg, 250 mg	Preferred	
hm stool softener oral capsule 100 mg	Preferred	
sm stool softener oral capsule 100 mg	Preferred	
sm stool softener oral tablet 100 mg	Preferred	
stool softener laxative oral capsule 100 mg	Preferred	
stool softener oral capsule 100 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
DOCUSOL KIDS RECTAL ENEMA 100 MG/5ML (*docusate sodium*)	Preferred	
DOCUSOL MINI RECTAL ENEMA 283 MG/5ML (*docusate sodium*)	Preferred	
DOK ORAL TABLET 100 MG (*docusate sodium*)	Preferred	
ENEMEEZ KIDS MINI ENEMA RECTAL ENEMA 100 MG/5ML (*docusate sodium*)	Preferred	
ENEMEEZ MINI RECTAL ENEMA 283 MG/5ML (*docusate sodium*)	Preferred	
ENEMEEZ PLUS RECTAL ENEMA 20-283 MG (*benzocaine-docusate sodium*)	Preferred	
PEDIA-LAX ORAL LIQUID 50 MG/15ML (*docusate sodium*)	Preferred	
SYSTEMIC DECONGESTANTS**		
12 hour nasal decongestant oral tablet extended release 12 hour 120 mg	Preferred	
ft nasal decongestant max str oral tablet 30 mg	Preferred	
ft nasal decongestant max str oral tablet extended release 12 hour 120 mg	Preferred	
ft nasal decongestant pe oral tablet 10 mg	Preferred	
gnp nasal decongestant oral tablet 30 mg	Preferred	
gnp nasal decongestant pe oral tablet 10 mg	Preferred	
gnp pseudoephedrine hcl 12 hr oral tablet extended release 12 hour 120 mg	Preferred	
nasal decongestant oral tablet 30 mg	Preferred	
nasal decongestant pe max st oral tablet 10 mg	Preferred	
nasal decongestant pe oral tablet 10 mg	Preferred	
phenylephrine hcl oral tablet 10 mg	Preferred	
pseudoephedrine hcl er oral tablet extended release 12 hour 120 mg	Preferred	
pseudoephedrine hcl oral tablet 30 mg, 60 mg	Preferred	
sinus 12 hour oral tablet extended release 12 hour 120 mg	Preferred	
sinus congestion max strength oral tablet 30 mg	Preferred	
sm nasal decongestant max st oral tablet 30 mg	Preferred	
sm nasal decongestant oral tablet extended release 12 hour 120 mg	Preferred	
suphedrine 12hour oral tablet extended release 12 hour 120 mg	Preferred	
SUDOGEST MAXIMUM STRENGTH ORAL TABLET 30 MG (*pseudoephedrine hcl*)	Preferred	
SUDOGEST ORAL TABLET 30 MG, 60 MG (*pseudoephedrine hcl*)	Preferred	
TAR PRODUCTS**		
sm anti-dandruff coal tar external shampoo 0.5 %	Preferred	

Drug Name	Formulary Status	Requirements/Limits
therapeutic external shampoo 0.5 %	Preferred	
DHS TAR EXTERNAL SHAMPOO 0.5 % (*coal tar extract*)	Preferred	
DHS TAR GEL EXTERNAL SHAMPOO 0.5 % (*coal tar extract*)	Preferred	
IONIL-T EXTERNAL SHAMPOO 1 % (*coal tar extract*)	Preferred	
TETRACYCLINES**		
doxycycline hyclate intravenous solution reconstituted 100 mg	Preferred	
doxycycline hyclate oral capsule 100 mg, 50 mg	Preferred	
doxycycline hyclate oral tablet 100 mg, 20 mg	Preferred	
doxycycline monohydrate oral capsule 100 mg, 50 mg	Preferred	
doxycycline monohydrate oral suspension reconstituted 25 mg/5ml	Preferred	
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	Preferred	
minocycline hcl oral capsule 100 mg, 75 mg	Preferred	QL (2 EA per 1 day)
minocycline hcl oral capsule 50 mg	Preferred	QL (4 EA per 1 day)
doxycycline hyclate (Doxy 100 Intravenous Solution Reconstituted 100 Mg)	Preferred	
THIAZIDES AND THIAZIDE-LIKE DIURETICS**		
chlorthalidone oral tablet 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
hydrochlorothiazide oral capsule 12.5 mg	Preferred	
hydrochlorothiazide oral tablet 12.5 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
indapamide oral tablet 1.25 mg, 2.5 mg	Preferred	
metolazone oral tablet 10 mg, 2.5 mg, 5 mg	Preferred	
THYROID HORMONES**		
levothyroxine sodium oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg	Preferred	90-day fill allowed after two 1-month fills
liothyronine sodium oral tablet 25 mcg, 5 mcg	Preferred	
niva thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	Preferred	
thyroid oral tablet 120 mg, 15 mg, 30 mg, 60 mg, 90 mg	Preferred	
ADTHYZA ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (*thyroid*)	Preferred	
ARMOUR THYROID ORAL TABLET 120 MG, 15 MG, 180 MG, 240 MG, 30 MG, 300 MG, 60 MG, 90 MG (*thyroid*)	Preferred	
levothyroxine sodium (Euthyrox Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	90-day fill allowed after two 1-month fills
levothyroxine sodium (Levo-T Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	90-day fill allowed after two 1-month fills
levothyroxine sodium (Levoxyl Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	90-day fill allowed after two 1-month fills

Drug Name	Formulary Status	Requirements/Limits
NP THYROID ORAL TABLET 120 MG, 15 MG, 30 MG, 60 MG, 90 MG (*thyroid*)	Preferred	
levothyroxine sodium (Unithroid Oral Tablet 100 Mcg, 112 Mcg, 125 Mcg, 137 Mcg, 150 Mcg, 175 Mcg, 200 Mcg, 25 Mcg, 300 Mcg, 50 Mcg, 75 Mcg, 88 Mcg)	Preferred	90-day fill allowed after two 1-month fills
TOPICAL ANESTHETIC COMBINATIONS**		
lidocaine-prilocaine external cream 2.5-2.5 %	Preferred	
TOPICAL DECONGESTANTS**		
12 hour nasal decongestant nasal solution 0.05 %	Preferred	
12 hour nasal spray nasal solution 0.05 %	Preferred	
ft nasal spray nasal solution 0.05 %	Preferred	
gnp nasal four spray nasal solution 1 %	Preferred	
gnp nasal spray extra moist nasal solution 0.05 %	Preferred	
gnp nasal spray fast acting nasal solution 1 %	Preferred	
gnp nasal spray nasal solution 0.05 %	Preferred	
gnp no drip nasal spray nasal solution 0.05 %	Preferred	
nasal decongestant spray nasal solution 0.05 %	Preferred	
nasal four nasal solution 1 %	Preferred	
nasal relief nasal solution 0.05 %	Preferred	
nasal spray 12 hour nasal solution 0.05 %	Preferred	
nasal spray extra moisturizing nasal solution 0.05 %	Preferred	
nasal spray no drip nasal solution 0.05 %	Preferred	
sinus nasal spray nasal solution 0.05 %	Preferred	
sinus relief extra strength nasal solution 1 %	Preferred	
sm nasal spray 12 hour nasal solution 0.05 %	Preferred	
sm nasal spray nasal solution 0.05 %	Preferred	
sm nasal spray sinus nasal solution 0.05 %	Preferred	
TRICYCLIC AGENTS**		
amitriptyline hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Preferred	
clomipramine hcl oral capsule 25 mg	Preferred	QL (4 EA per 1 day)
clomipramine hcl oral capsule 50 mg	Preferred	QL (5 EA per 1 day)
clomipramine hcl oral capsule 75 mg	Preferred	QL (3 EA per 1 day)
desipramine hcl oral tablet 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Preferred	
doxepin hcl oral capsule 10 mg, 100 mg, 150 mg, 25 mg, 50 mg, 75 mg	Preferred	
doxepin hcl oral concentrate 10 mg/ml	Preferred	
imipramine hcl oral tablet 10 mg, 25 mg, 50 mg	Preferred	
imipramine pamoate oral capsule 100 mg, 150 mg, 75 mg	Preferred	
nortriptyline hcl oral capsule 10 mg, 25 mg, 50 mg, 75 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
TRIPHASIC CONTRACEPTIVES - ORAL**		
alyacen 7/7/7 oral tablet 0.5/0.75/1-35 mg-mcg	Preferred	Max 365-day supply per 1 Fill
levonorg-eth estrad triphasic oral tablet 50-30/75-40/ 125-30 mcg	Preferred	Max 365-day supply per 1 Fill
norethindron-ethinyl estrad-fe oral tablet 1-20/1-30/1-35 mg-mcg	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic oral tablet 0.18/0.215/0.25 mg-35 mcg	Preferred	Max 365-day supply per 1 Fill
norethin-eth estrad triphasic (Aranelle Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estrad triphasic (Dasetta 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorg-eth estrad triphasic (Enpresse-28 Oral Tablet 50-30/75-40/ 125-30 Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estrad triphasic (Leena Oral Tablet 0.5/1/0.5-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorg-eth estrad triphasic (Levonest Oral Tablet 50-30/75-40/ 125-30 Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estrad triphasic (Nortrel 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethin-eth estrad triphasic (Nylia 7/7/7 Oral Tablet 0.5/0.75/1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindron-ethinyl estrad-fe (Tilia Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per 1 Fill
norethindron-ethinyl estrad-fe (Tri-Legest Fe Oral Tablet 1-20/1-30/1-35 Mg-Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Linyah Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Lo-Estarylla Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Lo-Marzia Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Lo-Mili Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Lo-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Mili Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Sprintec Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per 1 Fill
levonorg-eth estrad triphasic (Trivora (28) Oral Tablet 50-30/75-40/ 125-30 Mcg)	Preferred	Max 365-day supply per 1 Fill

Drug Name	Formulary Status	Requirements/Limits
norgestim-eth estrad triphasic (Tri-Vylibra Lo Oral Tablet 0.18/0.215/0.25 Mg-25 Mcg)	Preferred	Max 365-day supply per 1 Fill
norgestim-eth estrad triphasic (Tri-Vylibra Oral Tablet 0.18/0.215/0.25 Mg-35 Mcg)	Preferred	Max 365-day supply per 1 Fill
VELIVET ORAL TABLET 0.1/0.125/0.15 -0.025 MG (*desogestrel-ethinyl estradiol*)	Preferred	Max 365-day supply per 1 Fill
ULCER DRUGS - PROSTAGLANDINS**		
misoprostol oral tablet 100 mcg, 200 mcg	Preferred	
URINARY ANALGESICS**		
ft urinary pain relief oral tablet 95 mg	Preferred	
gnp urinary pain relief oral tablet 95 mg	Preferred	
hm urinary pain relief oral tablet 95 mg	Preferred	
phenazopyridine hcl oral tablet 100 mg, 200 mg, 95 mg	Preferred	
sm urinary pain relief max st oral tablet 97.5 mg	Preferred	
sm urinary pain relief oral tablet 95 mg	Preferred	
urinary pain relief oral tablet 95 mg	Preferred	
URO-PAIN ORAL TABLET 95 MG (*phenazopyridine hcl*)	Preferred	
URINARY ANTI-INFECTIVES**		
fosfomycin tromethamine oral packet 3 gm	Preferred	
methenamine hippurate oral tablet 1 gm	Preferred	
nitrofurantoin macrocrystal oral capsule 100 mg, 25 mg, 50 mg	Preferred	
nitrofurantoin monohyd macro oral capsule 100 mg	Preferred	
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS**		
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg, 50 mg	Preferred	
VASODILATORS**		
hydralazine hcl oral tablet 10 mg, 100 mg, 25 mg, 50 mg	Preferred	90-day fill allowed after two 1-month fills
minoxidil oral tablet 10 mg, 2.5 mg	Preferred	
VASOPRESSIN**		
desmopressin acetate oral tablet 0.1 mg, 0.2 mg	Preferred	
VASOPRESSORS**		
midodrine hcl oral tablet 10 mg, 2.5 mg, 5 mg	Preferred	
VISCOSUPPLEMENTS**		
EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE 20 MG/2ML (*sodium hyaluronate (viscosup)*)	Preferred	PA
VITAMIN A**		
true vitamin a oral capsule 10000 unit	Preferred	
vitamin a oral capsule 3 mg (10000 ut)	Preferred	
VITAMIN B-1**		
true vitamin b1 oral tablet 100 mg	Preferred	

Drug Name	Formulary Status	Requirements/Limits
vitamin b1 oral tablet 100 mg	Preferred	
vitamin b-1 oral tablet 100 mg	Preferred	
VITAMIN B-2**		
true vitamin b2 oral tablet 100 mg, 25 mg, 50 mg	Preferred	
VITAMIN B-3**		
niacin er oral capsule extended release 250 mg	Preferred	
niacin oral tablet 500 mg	Preferred	
true vitamin b3 oral tablet 100 mg, 250 mg, 50 mg, 500 mg	Preferred	
VITAMIN B-6**		
sm vitamin b-6 oral tablet 100 mg	Preferred	
true vitamin b6 oral tablet 100 mg, 25 mg, 50 mg	Preferred	
vitamin b-6 oral tablet 25 mg	Preferred	
VITAMIN C**		
ascorbic acid oral tablet 500 mg	Preferred	
sm chewable c oral tablet chewable 500 mg	Preferred	
sm vit c/rose hips oral tablet 1000 mg	Preferred	
sm vitamin c oral tablet 1000 mg, 250 mg	Preferred	
sm vitamin c oral tablet chewable 500 mg	Preferred	
sm vitamin c/rose hips oral tablet 500 mg	Preferred	
true vitamin c oral tablet 1000 mg, 250 mg, 500 mg	Preferred	
vitamin c oral tablet 500 mg	Preferred	
VITAMIN D**		
aqueous vitamin d oral liquid 10 mcg/ml	Preferred	
ergocalciferol oral capsule 1.25 mg (50000 ut)	Preferred	90-day fill allowed after two 1-month fills
ergocalciferol oral solution 200 mcg/ml	Preferred	
sm vitamin d3 oral tablet 25 mcg (1000 ut)	Preferred	
true vitamin d3 oral capsule 1.25 mg (50000 ut), 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut), 250 mcg (10000 ut), 50 mcg, 50 mcg (2000 ut)	Preferred	
true vitamin d3 oral tablet 1.25 mg (50000 ut), 10 mcg (400 unit), 125 mcg (5000 ut), 25 mcg (1000 ut)	Preferred	
vitamin d (ergocalciferol) oral capsule 1.25 mg (50000 ut), 50000 unit	Preferred	90-day fill allowed after two 1-month fills
vitamin d oral liquid 10 mcg/ml	Preferred	
vitamin d3 oral capsule 1.25 mg (50000 ut), 50 mcg (2000 ut)	Preferred	
vitamin d3 oral tablet 10 mcg (400 unit)	Preferred	
CALCIDOL ORAL SOLUTION 200 MCG/ML (*ergocalciferol*)	Preferred	
DECARA ORAL CAPSULE 1.25 MG (50000 UT) (*cholecalciferol*)	Preferred	
DIALYVITE VITAMIN D 5000 ORAL CAPSULE 125 MCG (5000 UT) (*cholecalciferol*)	Preferred	

Drug Name	Formulary Status	Requirements/Limits
DIALYVITE VITAMIN D3 MAX ORAL TABLET 1.25 MG (50000 UT) (*cholecalciferol*)	Preferred	
WEEKLY-D ORAL CAPSULE 1.25 MG (50000 UT) (*cholecalciferol*)	Preferred	
VITAMIN E**		
aqueous vitamin e oral solution 15 mg/0.67ml	Preferred	
true vitamin e oral capsule 180 mg, 450 mg, 90 mg	Preferred	
vitamin e oral capsule 180 mg (400 unit), 450 mg (1000 ut)	Preferred	
vitamin e oral solution 15 mg/0.67ml	Preferred	
VITAMIN K**		
phytonadione oral tablet 5 mg	Preferred	PA
ZINC**		
sm zinc gluconate oral tablet 50 mg	Preferred	
TOPICAL ANTIBIOTICS [OPEN CLASS]		
mupirocin external ointment 2 %	Preferred	
mupirocin calcium external cream 2 %	Non Preferred	PA
CENTANY AT EXTERNAL KIT 2 % (*mupirocin*)	Non Preferred	PA
CENTANY EXTERNAL OINTMENT 2 % (*mupirocin*)	Non Preferred	PA
ULCERATIVE COLITIS [OPEN CLASS]		
balsalazide disodium oral capsule 750 mg	Preferred	90-day fill allowed after two 1-month fills
mesalamine er oral capsule extended release 24 hour 0.375 gm	Preferred	90-day fill allowed after two 1-month fills
mesalamine er oral capsule extended release 500 mg	Preferred	90-day fill allowed after two 1-month fills
mesalamine oral capsule delayed release 400 mg	Preferred	
mesalamine oral tablet delayed release 1.2 gm, 800 mg	Preferred	
mesalamine rectal enema 4 gm	Preferred	
mesalamine rectal suppository 1000 mg	Preferred	
sulfasalazine oral tablet 500 mg	Preferred	90-day fill allowed after two 1-month fills
sulfasalazine oral tablet delayed release 500 mg	Preferred	90-day fill allowed after two 1-month fills
APRISO ORAL CAPSULE EXTENDED RELEASE 24 HOUR 0.375 GM (*mesalamine*)	Preferred	90-day fill allowed after two 1-month fills
PENTASA ORAL CAPSULE EXTENDED RELEASE 250 MG, 500 MG (*mesalamine*)	Preferred	90-day fill allowed after two 1-month fills
budesonide er oral tablet extended release 24 hour 9 mg	Non Preferred	PA
budesonide rectal foam 2 mg, 2 mg/act	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
mesalamine-cleanser rectal kit 4 gm	Non Preferred	PA
AZULFIDINE EN-TABS ORAL TABLET DELAYED RELEASE 500 MG (*sulfasalazine*)	Non Preferred	PA
AZULFIDINE ORAL TABLET 500 MG (*sulfasalazine*)	Non Preferred	PA
CANASA RECTAL SUPPOSITORY 1000 MG (*mesalamine*)	Non Preferred	PA
COLAZAL ORAL CAPSULE 750 MG (*balsalazide disodium*)	Non Preferred	PA
DELZICOL ORAL CAPSULE DELAYED RELEASE 400 MG (*mesalamine*)	Non Preferred	PA
DIPENTUM ORAL CAPSULE 250 MG (*olsalazine sodium*)	Non Preferred	PA
LIALDA ORAL TABLET DELAYED RELEASE 1.2 GM (*mesalamine*)	Non Preferred	PA
ROWASA RECTAL KIT 4 GM (*mesalamine-cleanser*)	Non Preferred	PA
SFROWASA RECTAL ENEMA 4 GM/60ML (*mesalamine*)	Non Preferred	PA
UCERIS ORAL TABLET EXTENDED RELEASE 24 HOUR 9 MG (*budesonide*)	Non Preferred	PA
UCERIS RECTAL FOAM 2 MG/ACT (*budesonide*)	Non Preferred	PA
URINARY ANTISPASMOTICS [OPEN CLASS]		
oxybutynin chloride er oral tablet extended release 24 hour 10 mg, 15 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
oxybutynin chloride oral solution 5 mg/5ml	Preferred	90-day fill allowed after two 1-month fills
oxybutynin chloride oral tablet 2.5 mg	Preferred	
oxybutynin chloride oral tablet 5 mg	Preferred	90-day fill allowed after two 1-month fills
solifenacin succinate oral tablet 10 mg, 5 mg	Preferred	90-day fill allowed after two 1-month fills
trospium chloride er oral capsule extended release 24 hour 60 mg	Preferred	
TOVIAZ ORAL TABLET EXTENDED RELEASE 24 HOUR 4 MG, 8 MG (*fesoterodine fumarate*)	Preferred	90-day fill allowed after two 1-month fills
darifenacin hydrobromide er oral tablet extended release 24 hour 15 mg, 7.5 mg	Non Preferred	PA
fesoterodine fumarate er oral tablet extended release 24 hour 4 mg, 8 mg	Non Preferred	PA
flavoxate hcl oral tablet 100 mg	Non Preferred	PA
mirabegron er oral tablet extended release 24 hour 25 mg, 50 mg	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
tolterodine tartrate er oral capsule extended release 24 hour 2 mg, 4 mg	Non Preferred	PA
tolterodine tartrate oral tablet 1 mg, 2 mg	Non Preferred	PA
trospium chloride oral tablet 20 mg	Non Preferred	PA
DETROL LA ORAL CAPSULE EXTENDED RELEASE 24 HOUR 2 MG, 4 MG (*tolterodine tartrate*)	Non Preferred	PA
DETROL ORAL TABLET 1 MG, 2 MG (*tolterodine tartrate*)	Non Preferred	PA
GELNIQUE TRANSDERMAL GEL 10 % (*oxybutynin chloride*)	Non Preferred	PA
GEMTESA ORAL TABLET 75 MG (*vibegron*)	Non Preferred	PA
MYRBETRIQ ORAL SUSPENSION RECONSTITUTED ER 8 MG/ML (*mirabegron*)	Non Preferred	PA
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG (*mirabegron*)	Non Preferred	PA
OXYTROL FOR WOMEN TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (*oxybutynin*)	Non Preferred	PA
OXYTROL TRANSDERMAL PATCH TWICE WEEKLY 3.9 MG/24HR (*oxybutynin*)	Non Preferred	PA
VESICARE LS ORAL SUSPENSION 5 MG/5ML (*solifenacin succinate*)	Non Preferred	PA
VESICARE ORAL TABLET 10 MG, 5 MG (*solifenacin succinate*)	Non Preferred	PA
VACCINES		
BACTERIAL VACCINES**		
BIOTHRAX INTRAMUSCULAR SUSPENSION (*anthrax vaccine adsorbed*)	Preferred	QL (2.50 ML per Lifetime); AGE (Min 19 Years)
CAPVAXIVE INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (*pneumococcal 21-valent conjuga*)	Preferred	AGE (Min 18 Years)
PREVNAR 20 INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*pneumococcal 20-val conj vacc*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
TYPHIM VI INTRAMUSCULAR SOLUTION 25 MCG/0.5ML (*typhoid vi polysaccharide vacc*)	Preferred	QL (0.50 ML per Lifetime); AGE (Min 19 Years)
TYPHIM VI INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 25 MCG/0.5ML (*typhoid vi polysaccharide vacc*)	Preferred	QL (0.50 ML per Lifetime); AGE (Min 19 Years)
VAXCHORA ORAL SUSPENSION RECONSTITUTED (*cholera vac live attenuated*)	Preferred	QL (100.00 ML per Lifetime); AGE (Min 19 Years)
VAXNEUVANCE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*pneumococcal 15-val conj vacc*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
VIVOTIF ORAL CAPSULE DELAYED RELEASE (*typhoid vaccine*)	Preferred	QL (4.00 ML per Lifetime); AGE (Min 19 Years)

Drug Name	Formulary Status	Requirements/Limits
TOXOID COMBINATIONS**		
tetanus-diphtheria toxoids td intramuscular suspension 2-2 lf/0.5ml	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
PENTACEL INTRAMUSCULAR SUSPENSION RECONSTITUTED (*dtap-ipv-hib vaccine*)	Preferred	PA; AGE (Min 19 Years)
TDVAX INTRAMUSCULAR SUSPENSION 2-2 LF/0.5ML (*tetanus-diphtheria toxoids td*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
TENIVAC INTRAMUSCULAR INJECTABLE 5-2 LFU (*tetanus-diphtheria toxoids td*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
VAXELIS INTRAMUSCULAR SUSPENSION (*dtap-ipv-hib-hepatitis b recmb*)	Preferred	PA; AGE (Min 19 Years)
VAXELIS INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE (*dtap-ipv-hib-hepatitis b recmb*)	Preferred	PA; AGE (Min 19 Years)
VIRAL VACCINE COMBINATIONS**		
TWINRIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 720-20 ELU-MCG/ML (*hepatitis a-hep b recomb vac*)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
VIRAL VACCINES**		
stamaril injection suspension reconstituted	Preferred	QL (1.00 ML per Lifetime); AGE (Min 19 Years)
ABRYSVO INTRAMUSCULAR SOLUTION RECONSTITUTED 120 MCG/0.5ML (*rsv pre-fusion f a&b vac rcmb*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 19 Years)
ACAM2000 INJECTION SOLUTION RECONSTITUTED (*smallpox vaccine*)	Preferred	
AFLURIA INTRAMUSCULAR SUSPENSION (*influenza virus vaccine split*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
AFLURIA PRESERVATIVE FREE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
AREXVY INTRAMUSCULAR SUSPENSION RECONSTITUTED 120 MCG/0.5ML (*rsvpref3 vac recomb adjuvanted*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 60 Years)
ENGERIX-B INJECTION SUSPENSION 20 MCG/ML (*hepatitis b vac recombinant*)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
ENGERIX-B INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/0.5ML, 20 MCG/ML (*hepatitis b vac recombinant*)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
FLUAD INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza vac a&b surf ant adj*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUARIX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUBLOK INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 0.5 ML (*influenza vac recombinant ha*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION (*influenza vac tiss-cult subunt*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUCELVAX INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza vac tiss-cult subunt*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLULAVAL INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)

Drug Name	Formulary Status	Requirements/Limits
FLUMIST NASAL LIQUID (*influenza virus vaccine live*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 18 Years)
FLUZONE HIGH-DOSE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza vac split high-dose*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 65 Years)
FLUZONE INTRAMUSCULAR SUSPENSION (*influenza virus vaccine split*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
FLUZONE INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 0.5 ML (*influenza virus vacc split pf*)	Preferred	QL (1 Fill per 180 Days); AGE (Min 19 Years)
HEPLISAV-B INTRAMUSCULAR SOLUTION PREFILLED SYRINGE 20 MCG/0.5ML (*hepatitis b vac recomb adj*)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
IMOVAX RABIES INTRAMUSCULAR SUSPENSION RECONSTITUTED 2.5 UNIT/ML (*rabies virus vaccine, hdc*)	Preferred	
IPOL INJECTION INJECTABLE (*poliovirus vaccine inactivated*)	Preferred	QL (1.50 ML per Lifetime); AGE (Min 19 Years)
IXCHIQ INTRAMUSCULAR SOLUTION RECONSTITUTED (*chikungunya virus vaccine live*)	Preferred	QL (0.50 ML per Lifetime); AGE (Min 19 Years)
IXIARO INTRAMUSCULAR SUSPENSION (*japanese encephalitis vac inac*)	Preferred	QL (1.00 ML per Lifetime); AGE (Min 19 Years)
JYNNEOS SUBCUTANEOUS SUSPENSION 0.5 ML (*smallpox & monkeypox vac, live*)	Preferred	
MRESVIA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 50 MCG/0.5ML (*rsv mrna pre-f virus vaccine*)	Preferred	QL (1 Fill per Lifetime); AGE (Min 60 Years)
RECOMBIVAX HB INJECTION SUSPENSION 10 MCG/ML, 5 MCG/0.5ML (*hepatitis b vac recombinant*)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
RECOMBIVAX HB INJECTION SUSPENSION PREFILLED SYRINGE 10 MCG/ML, 5 MCG/0.5ML (*hepatitis b vac recombinant*)	Preferred	QL (3 Fills per Lifetime); AGE (Min 19 Years)
SHINGRIX INTRAMUSCULAR SUSPENSION RECONSTITUTED 50 MCG/0.5ML (*zoster vac recomb adjuvanted*)	Preferred	QL (2 Fills per Lifetime); AGE (Min 18 Years)
TICOVAC INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1.2 MCG/0.25ML, 2.4 MCG/0.5ML (*tick-borne encephalitis vacc*)	Preferred	QL (1.50 ML per Lifetime); AGE (Min 19 Years)
YF-VAX SUBCUTANEOUS INJECTABLE (*yellow fever vaccine*)	Preferred	QL (1.00 ML per Lifetime); AGE (Min 19 Years)
VAGINAL ANTIBIOTICS [OPEN CLASS]		
metronidazole vaginal gel 0.75 %	Preferred	
CLEOCIN VAGINAL SUPPOSITORY 100 MG (*clindamycin phosphate*)	Preferred	
CLINDESSE VAGINAL CREAM 2 % (*clindamycin phosphate (1 dose)*)	Preferred	
NUVESSA VAGINAL GEL 1.3 % (*metronidazole*)	Preferred	
clindamycin phosphate vaginal cream 2 %	Non Preferred	PA
CLEOCIN VAGINAL CREAM 2 % (*clindamycin phosphate*)	Non Preferred	PA

Drug Name	Formulary Status	Requirements/Limits
VANDAZOLE VAGINAL GEL 0.75 % (*metronidazole*)	Non Preferred	PA
XACIATO VAGINAL GEL 2 % (*clindamycin phosphate*)	Non Preferred	PA
VAGINAL ESTROGENS [OPEN CLASS]		
estradiol vaginal cream 0.1 mg/gm	Preferred	
estradiol vaginal tablet 10 mcg	Preferred	AGE (Min 18 Years)
PREMARIN VAGINAL CREAM 0.625 MG/GM (*estrogens, conjugated*)	Preferred	
VAGIFEM VAGINAL TABLET 10 MCG (*estradiol*)	Preferred	AGE (Min 18 Years)
estradiol (Yuvafem Vaginal Tablet 10 Mcg)	Preferred	AGE (Min 18 Years)
ESTRACE VAGINAL CREAM 0.1 MG/GM (*estradiol*)	Non Preferred	PA
ESTRING VAGINAL RING 2 MG, 7.5 MCG/24HR (*estradiol*)	Non Preferred	PA
FEMRING VAGINAL RING 0.05 MG/24HR, 0.1 MG/24HR (*estradiol acetate*)	Non Preferred	PA
IMVEXXY MAINTENANCE PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*)	Non Preferred	PA
IMVEXXY STARTER PACK VAGINAL INSERT 10 MCG, 4 MCG (*estradiol*)	Non Preferred	PA
WEIGHT MANAGEMENT AGENTS [CLOSED CLASS]		
benzphetamine hcl oral tablet 50 mg	Preferred	PA; AGE (Min 16 Years)
diethylpropion hcl er oral tablet extended release 24 hour 75 mg	Preferred	PA; AGE (Min 16 Years)
diethylpropion hcl oral tablet 25 mg	Preferred	PA; AGE (Min 16 Years)
orlistat oral capsule 120 mg	Preferred	PA; AGE (Min 12 Years)
phendimetrazine tartrate er oral capsule extended release 24 hour 105 mg	Preferred	PA; AGE (Min 16 Years)
phendimetrazine tartrate oral tablet 35 mg	Preferred	PA; AGE (Min 16 Years)
phentermine hcl oral capsule 15 mg, 30 mg, 37.5 mg	Preferred	PA; AGE (Min 16 Years)
phentermine hcl oral tablet 37.5 mg	Preferred	PA; AGE (Min 16 Years)
XENICAL ORAL CAPSULE 120 MG (*orlistat*)	Preferred	PA; AGE (Min 12 Years)
IMCIVREE SUBCUTANEOUS SOLUTION 10 MG/ML (*setmelanotide acetate*)	Non Preferred	SP; PA; AGE (Min 6 Years)
SAXENDA SUBCUTANEOUS SOLUTION PEN-INJECTOR 18 MG/3ML (*liraglutide -weight management*)	Non Preferred	PA; AGE (Min 12 Years)
WEGOVY SUBCUTANEOUS SOLUTION AUTO-INJECTOR 0.25 MG/0.5ML, 0.5 MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML (*semaglutide-weight management*)	Non Preferred	PA; AGE (Min 12 Years)
ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.5ML, 12.5 MG/0.5ML, 15 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML (*tirzepatide-weight management*)	Non Preferred	PA; QL (2 ML per 28 days); AGE (Min 18 Years)

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